FILED
JUN 14 1980
MICHAEL RODAK, JR., CLERK

80-60

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1979

No._____

ELVINA M. HERWEG, by her husband and next friend, Darrell E. Herweg; and DARRELL E. HERWEG, on behalf of themselves and all others similarly situated,

Petitioners,

vs.

ROBERT D. RAY, individually and in his capacity as Governor of the State of Iowa; and KEVIN J. BURNS, individually and in his capacity as Commissioner of the Iowa Department of Social Services,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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QUESTION PRESENTED

Whether the Court of Appeals' invalidation of a regulation promulgated by the Department of Health and Human Services which was designed

to ensure that, in the so-called "SSI states," Medicaid applicants and recipients would have the eligibility conditions and rules of the Supplemental Security Income ("SSI") program applied to them was appropriate in light of the explicit requirements of the Medicaid and SSI statutes and the deference due the responsible federal agency.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
Table of Authorities	iv
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS	2
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE WRIT	16
CONCLUSION	32
APPENDICES	

TABLE OF AUTHORITIES

Cases	Page
Allen v. Califano, No. C-78-0212 (D. Utah, Aug. 22, 1979), appeal pending No. 79-2167 (10th Cir.)	17
Beal v. Doe, 432 U.S. 438 (1977)	4
Brown v. Stanton, 617 F.2d 1224 (7th Cir. 1980), pet. for cert. filed No. 79-1690, 48 U.S.L.W. 3735 (April 25, 1980)	17
Caldwell v. Blum, ___ F.2d ___, CCH Medicare & Medicaid Guide, par. 30,453 (2d Cir. 1980), stay denied No. A946, ___ U.S. ___, 100 S.Ct. 1635 (1980) (Marshall J.), stay again denied, ___ U.S. ___, 48 U.S.L.W. 3785 (June 2, 1980) (en banc)	19, 26
Dawson v. Myers, ___ F.2d ___, CCH Medicare & Medicaid Guide, par. 30,501 (9th Cir. 1980)	26
Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979)	3, 18 26

Friedman v. Berger,
547 F.2d 724 (2d Cir. 1976),
cert. den. 430 U.S. 984 (1977) 4, 18

Gray Panthers v. Secretary, Dept. of H.E.W.,
461 F.Supp. 319 (D.D.C. 1978),
appeal pending No. 79-1334
(D.C. Cir., argued Jan. 15, 1980) 7, 17, 18, 21

Griswold v. Page,
TCA 77-0712, CCH Medicare & Medicaid Guide, par. 28,537
(N.D. Fla. 1977) 29

Hayes v. Stanton,
512 F.2d 133 (7th Cir. 1975) 18, 21

Hendrickson v. Noot,
___ F.Supp. ___, CCH Medicare & Medicare Guide, par. 30,499
(D. Minn. 1980) 26

Herweg v. Ray,
No. 78-1664 (8th Cir., March 18, 1980) 3, 8

Herweg v. Ray,
443 F.Supp. 1315, later opinion
481 F.Supp. 914 (S.D. Iowa 1978) 8

Hodgson v. Board of County Commissioners,
614 F.2d 601 (8th Cir. 1980) 2

Manfredi v. Maher,
435 F.Supp. 1106 (D. Conn. 1977) 21

Marquette National Bank v.
First of Omaha Service Corp.,
99 S.Ct. 540 (1978) 31

Miller v. Youakim,
99 S.Ct. 957 (1979) 31

Norman v. St. Clair,
610 F.2d 1228 (5th Cir. 1980) 4, 7, 16
20, 21

Preterm, Inc. v. Dukakis,
591 F.2d 121 (1st Cir.),
cert. den. 441 U.S. 952 (1979) 3

Rosado v. Wyman,
397 U.S. 397 (1970) 4

West v. Cole,
390 F.Supp. 91 (N.D. Miss. 1975) 21

Statutes

Public Law No. 93-233, §13 (1973) 19

United States Code, Title 28:

Section 1254(1) 1

Section 1331 10

Sections 1343(3), (4) 10

United States Code, Title 42:

Sections 1381, et seq.	5
Sections 1382(b)(1), (2)	28
Section 1382c(b)	28
Section 1382c(f)(1)	27
Section 1382e	23
Section 1382(e)(1)(B)	23
Section 1396a	3
Section 1396a(a)(10)	2, 18
Section 1396a(a)(10)(A)	4, 15, 19
Section 1396a(a)(10)(C)	4
Section 1396a(a)(10)(C)(III)	5, 23
Section 1396a(a)(14)	25
Section 1396a(a)(17)	2, 14, 15
Section 1396a(a)(17)(B)	14, 18
Section 1396a(a)(17)(D)	15

United States Code, Title 42:

Section 1396a(b) 3

Section 1396a(f) 2, 4, 5 21, 29

Section 1396b 3

Section 1396b(f)(4)(C) 23

Section 1396c 4

Section 1983 10

Acts of the 67th Iowa General Assembly, House File 464, section 18 8

Regulations

Code of Federal Regulations, Title 42:

part 436 5

Section 435.211 23

Section 435.230 23

Section 435.231 23

Section 435.723 2, 8, 13, 16

Section 435.723(c) 7

Section 435.723(d) 12

Section 448.3(b) 7

Code of Federal Regulations, Title 45

Section 248.3(b) 6, 7

Iowa Department of Social Services, Manual Letter No. XXI-1-28 (part 2) (June 3, 1977) 8, 9

Miscellaneous

Federal Register, Volume 40
page 60074 (Dec. 31, 1975) 6, 22

Federal Register, Volume 42
pages 2684, et seq. (Jan. 13, 1977) 6
page 2685 (Jan. 13, 1977) 6, 22, 26
page 52827 (Sept. 30, 1977) 7

Federal Register, Volume 43
pages 45176, et seq. (Sept. 29, 1978) 7

Federal Register, Volume 44
page 10553 (Feb. 21, 1979) 3

House Report No. 92-231, 92d Cong., 2d Sess. (1972), reprinted in [1972] U.S. Code Cong. & Admin. News, 5136 25

Senate Report No. 93-553, 93d Cong., 1st Sess. (1973) 25

OPINIONS BELOW

The opinion of the Court of Appeals, which is not yet reported, appears as Appendix "A". The district court Memorandum Opinion and Order of January 19, 1978, reported at 443 F.Supp. 1315, and the district court's Ruling and Order of July 10, 1978, reported at 481 F.Supp. 914, are attached as Appendices "B" and "C", respectively. The Final Judgment of August 4, 1978 appears as Appendix "D".

JURISDICTION

The Court of Appeals, en banc, filed its order and judgment on March 18, 1980. On April 22, 1980, a timely petition for rehearing was denied (Appendix "E"). This petition for certiorari is being filed within 90 days of the denial of the petition for rehearing. This Court's jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS

The following statutes and regulations relevant to the consideration of this petition are set out verbatim in Appendix "F":

42 U.S.C. §1396a(a)(10)
42 U.S.C. §1396a(a)(17)
42 U.S.C. §1396a(f)
42 C.F.R. §435.723

STATEMENT OF THE CASE

1. The Medical Assistance program, commonly known as Medicaid,

> "is a cooperative federal-state program established in 1965, in Title XIX of the Social Security Act . . . , 42 U.S.C. §1396, et seq. The basic purpose of Medicaid is to enable each state, as far as practicable under the conditions in each state, to furnish medical assistance to certain needy persons whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. §1396; e.g., Beal v. Doe, 432 U.S. 438, 444 (1977); Hodgson v. Board of County Commissioners, [614 F.2d 601, 606 n.8 (8th Cir. 1980)] . . . . The Medicaid program is jointly financed by the federal and state governments and administered

by the states." Herweg v. Ray, No. 78-1664 Sl.Op., at 24 (8th Cir., March 18, 1980) (McMillian, J., concurring in part, dissenting in part); (App. "A", at 34a); see also, e.g., Preterm, Inc. v. Dukakis, 591 F.2d 121, 124 (1st Cir.), cert. denied 441 U.S. 592 (1979); Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979). [1/]

Although a state is not required to participate in Medicaid, it is encouraged to join by the reimbursement it receives from the federal government. In Iowa's case, this amounts to 56.57% of the costs incurred. 42 U.S.C. §1396b; 44 Fed.Reg. 10553 (Feb. 21, 1979). In order to participate, the state must submit a "state plan" to the Secretary of the Department of Health and Human Services (formerly "HEW" and hereinafter "HHS") which describes the nature and scope of its planned Medicaid program. 42 U.S.C. §1396a. The state is supposed to meet the requirements of federal law in order to be reimbursed for its expenditures. 42 U.S.C. §§1396a(b), 1396b; McM.Op. at 24-25 (App. "A", at 34a-35a). See also, e.g., Fabula v. Buck, supra, 598 F.2d, at 870-871. In practice, though, as

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1/ The eight members of the court split evenly on the issue presented to this Court. For convenience, therefore, petitioners will hereinafter refer to the decision which resulted in affirmance of the district court, authored by Judge Ross, as the "Ross Op.," while that written by Judge McMillian will henceforth be termed the "McM.Op."

the sole sanction available to the Secretary of HHS is the cessation of payments to the state, 42 U.S.C. §1396c, HHS undertakes a seemingly endless process to curb improper state rules and allows the illegal practice to continue during the process, as it did in this instance. See generally Rosado v. Wyman, 397 U.S. 397, 405 n.8 (1970).

A key element of the federal Medicaid scheme is the flexibility which it allows the states. Thus, although a state must operate within the guidelines established by federal statute and regulations, it has numerous options available to it in establishing the contours of its program. The state must provide assistance to the so-called "categorically needy," but the precise delineation of that group is left to the discretion of the state. Compare 42 U.S.C. §1396a(a)(10)(A) with 42 U.S.C. §1396a(f); see McM.Op., at 33-38 (App. A, at 45a-51a); see generally Beal v. Doe, supra, 432 U.S., at 440 and n.1; Friedman v. Berger, 547 F.2d 724 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977); Norman v. St. Clair, 610 F.2d 1228, 1230-1231 (5th Cir. 1980). In general terms, the categorically needy are those who meet the categorical definitions of being aged, blind, disabled, or dependent children, and who have income and resources below certain levels. Furthermore, a state may provide a program for the so-called "medically needy," 42 U.S.C. §1396a(a)(10)(C), who are those meeting the categorical definitions but with income or resources above the categorically needy levels. See, e.g., Norman v. St. Clair, supra, 610 F.2d, at 1231. Also, a state may provide categorically needy coverage to certain optional groups, such as some institutionalized individuals, who are not

actually receiving cash assistance and would therefore otherwise be ineligible as categorically needy. 42 U.S.C. §1396a(a)(10)(C)(III). See generally McM. Op., at 39-40 (App. A, at 52a-53a).

Iowa elected not to cover the medically needy, but it did include coverage for certain of the optional categorical groups. It also decided not to be a so-called "209(b) state" pursuant to 42 U.S.C. §1396a(f), which would have allowed it to use eligibility conditions for the categorically needy more restrictive than those used in the Supplemental Security Income ("SSI") program, 42 U.S.C. §§1381, et seq., Title XVI of the Social Security Act, but no more restrictive than those in effect in a state's program on January 1, 1972. By thus becoming an "SSI state," Iowa, like about two-thirds of the states, has elected to tie Medicaid eligibility for the categorically needy aged, blind, and disabled to the SSI statute. 2/

2/ At present, fifty-three jurisdictions have Medicaid programs. Arizona is the only state without one. Fifteen states have selected the "209(b) option," while thirty-four states and the District of Columbia are "SSI states." SSI does not apply to Guam, Puerto Rico, and the Virgin Islands, and Medicaid eligibility is there based on the old state-administered categorical assistance programs for the aged, blind, and disabled. See 42 C.F.R., Part 436.

In December, 1975, HHS proposed amended regulations which were intended to specify explicitly the relationship between SSI and Medicaid for purposes of calculating income and resources in determining Medicaid eligibility and amount of assistance. 40 Fed. Reg. 60074 (Dec. 31, 1975). These proposed regulations were offered nearly two years after the SSI statute went into effect and after states were given the option of tying Medicaid eligibility to SSI eligibility or of using their more restrictive prior rules. These proposed new regulations, then to be codified in relevant part at 45 C.F.R. §248.3(b), were intended to replace the regulations which were based exclusively on the language of the Medicaid statute and which did not draw any connection between Medicaid and SSI eligiblity. See 40 Fed. Reg. 60074, column 2, note 4. Like other interested parties, the states were given the opportunity to comment on these proposed regulations. 40 Fed. Reg. 60074.

More than a year after their publication, the proposed regulations, in revised form, were re-published, with an effective date of April 13, 1977. 42 Fed. Reg. 2684, et seq. (Jan. 13, 1977). As is customary, HHS included with the new regulations a synopsis of the comments which had been received and an explanation as to why these new regulations were required. In brief, it was the relationship between SSI and Medicaid, and the need to ensure that all SSI-eligibles in the "SSI states" would be automatically eligible for Medicaid, which HHS saw as the determinative factor in the promulgation of these new regulations. See id., at 2685.

The proposed new regulations, which were ultimately published in their present form at 42 C.F.R. §435.723,[3] controlled the procedure generally known as "deeming." Under this process, income or resources could be considered available to an individual whether in fact they were actually available; the term "deeming" was used because the assets were deemed available. The then-new regulations specifically forbid "SSI states" from deeming the income and resources of a non-institutionalized spouse available to an institutionalized spouse after either the calendar month of institutionalization or after six months of institutionalization, depending on the eligibility status of the non-institutionalized spouse.[4] Tracking the relevant portions of the SSI statute, the regulations effectively required the state to treat the spouses as separate economic

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[3] 45 C.F.R. §248.3(b) was redesignated as 42 C.F.R. §448.3(b). 42 Fed. Reg. 52827 (Sept. 30, 1977). A year later, HEW rewrote - but with no "policy changes" - and redesignated its Medicaid regulations. See 43 Fed. Reg. 45176, et seq. (Sept. 29, 1978). The relevant parts of 42 C.F.R. §448.3(b) became 42 C.F.R. §435.723. See Norman v. St. Clair, supra, 610 F.2d, at 1235 n.12; Gray Panthers v. Secretary, Dept. of H.E.W., 461 F.Supp. 319, 320 n.2 (D.D.C. 1978), appeal pending No. 79-1334 (D.C. Cir., argued Jan. 15, 1980).

[4] Compare 42 C.F.R. §435.723(c) with 435.723(d).

units after the one- or six-month period of institutionalization had passed.

Iowa explicitly balked at employing these rules. The Iowa General Assembly instructed the state Department of Social Services to "resist the implementation" of these regulations. House File 464, section 18, Acts of the 67th General Assembly. The Department complied by issuing its Manual Letter No. XXI-1-28 (part 2) on June 3, 1977. Herweg v. Ray, No. 77-22-1, App. "B", at 76a (443 F.Supp., at 1316-1317). Under this directive, a portion of the income of the non-institutionalized spouse, computed by use of an arbitrary formula which did not take into account the individual needs and expenses of that spouse, was assumed available to the institutionalized spouse, regardless of whether the deemed amount accurately reflected the financial situation of the non-institutionalized spouse and regardless of whether in fact the non-institutionalized spouse made the contribution.

Iowa resisted HHS' compliance efforts. In a letter to the HHS regional commissioner in Kansas City on June 15, 1977, defendant Burns defended Iowa's decisions on the grounds that "[w]e have determined that the revised regulations . . . are not in the best interest of the state or its citizens." Appendix to Brief of Appellants, filed below, at 36. Thus, from the date of the implementation of the regulations at issue, April 13, 1977, the state of Iowa has been explicitly, directly, and intentionally in violation of those regulations.

2. Plaintiffs Elvina and Darrell Herweg were married on July 30, 1949.[5/] Elvina Herweg has been in a comatose state since suffering aneurisms and cerebral hemorrhages on both sides of her head in August, 1976. She was placed in a long-term care facility on November 1, 1976.

The rest of her family, consisting of her husband, Darrell, and their three teenage daughters, continued to live at their home in Council Bluffs, Iowa. Mr. Herweg was employed as a butcher, and had a net take-home pay of $1,032 per month at that time. He applied for Medicaid for his wife in January, 1977, and after an initial determination of eligibility, his monthly contribution (i.e., the deemed amount) was set at $234.80.

Using the procedure for calculating available income set out in Manual Letter No. XXI-1-28, though, the Department of Social Services issued a Notice of Decision on June 2, 1977 informing them that because of a higher deemed amount, she would be ineligible for assistance effective June 30, 1977. That decision was affirmed on July 21, 1977. Since the approximate monthly cost of her care was then $1,374, and he obviously could not afford this amount, they brought this action. App. "B", at 78a (443 F.Supp., at 1316-1317).

[5/] The details of their situation, including the financial aspects, are set out in the district court decision, App. "B", at 77a-78a (443 F.Supp., at 1316-1317).

3. This class action was filed in district court on July 28, 1977 with the causes brought under 42 U.S.C. §1983 and jurisdiction alleged under 28 U.S.C. §§1343(3), (4), and 1331.[6/] On that same date, Chief Judge Stuart granted the request for a temporary restraining order. On August 11, 1977, the Iowa Department of Social Services issued a new "Proposed Decision" which modified the formula calculations; under the new determination, she was eligible, but $150.30 of his monthly income was still to be deemed to her. If he failed to make the payment, "eviction would be imminent." App. "B", at 78a-79a (443 F.Supp., at 1317).

The plaintiffs filed an amended complaint on September 15, 1977, elaborating on their arguments against the state's deeming policy. After the parties stipulated to the material facts, the district court issued its initial decision on January 19, 1978. The court held that the Medicaid statute precluded the use of an arbitrary formula in determining the amount to be deemed, and that an individualized factual determination had to be made in each case. App. "B", at 83a-84a (443 F.Supp., at 1319, 1320). It held further that the state "procedures are also contrary to

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6/ The district court found jurisdiction proper under all of those sections, App. "B", at 77a (443 F.Supp., at 1316), and the Court of Appeals saw the district court's jurisdiction as proper under §1343(3). Ross Op., at 6 (App. "A", at 10a).

[the federal] regulations which arbitrarily refuse to impute the income of a non-institutionalized spouse to defray expenses of an institutionalized spouse." App. "B", at 86a (443 F.Supp., at 1320). The court expressed doubt, though, as to the propriety of the federal regulations, but it refused to reject them outright because "[the Secretary and HHS] are not represented in this action and it is therefore not appropriate to make a finding on the validity of that section." App. "B", at 87a (443 F.Supp., at 1320). The district court certified the requested class and issued a permanent injunction "against state 'deeming' procedures." App. "B", at 87a-88a (443 F.Supp., at 1320).

Because of the parties' uncertainty as to the precise meaning of the decision and its implementation, they returned to the district court for further elaboration. The court issued a second Ruling and Order on July 10, 1978. App. "C" (481 F.Supp. 914). In that Order, Judge Stuart agreed with plaintiffs that "anti-alienation" provisions forbade consideration of the Social Security, Civil Service, and Railroad Retirement benefits of a non-institutionalized spouse, and therefore required that they be disregarded in computing income of the non-institutionalized spouse. Furthermore, he agreed in principle to the notice prepared by plaintiffs by which members of the class would be informed of their potential eligibility for reimbursement of the amounts illegally deemed from them since the filing of the complaint. And, finally, he elaborated on his previous discussion of the propriety of deeming, concluding, in effect, that

as long as an arbitrary formula was not employed, the state was permitted to deem a contribution available from the non-institutionalized spouse. App. "C", at 92a (481 F.Supp., at 916-917). He did not further discuss the applicable federal regulations.

Judge Stuart summarized and incorporated his two decisions into a Final Judgment and Final Order which was filed on August 4, 1978. Plaintiffs timely appealed to the Eighth Circuit, contending that federal law did not permit a state to assume or deem any income or resources available, regardless of whether an individualized determination was used to compute the "reasonable" contribution of the non-institutionalized spouse. The defendants did not appeal any aspect of the district court's orders and decisions.

The appeal was initially argued before a three-judge panel of the Court of Appeals on January 12, 1979.[7/] No decision ever issued from that panel; submission of the appeal was vacated on August 10, 1979 by the Court sua sponte. It was set for re-argument en banc on September 10, 1979. In addition, by letter, the court asked the then-Department of Health, Education and Welfare to submit a brief amicus curiae "specifically" directed at the validity of "the regulation at issue (42 C.F.R. §435.723(d))

7/ The members of the panel were Circuit Judges Ross and McMillian, and District Judge Van Sickle, sitting by designation.

. . . ." The brief submitted by HHS was its first and sole participation in this case. It was not asked to participate in oral argument.

In the Court of Appeals' order and decision of March 18, 1980, the district court's judgment on the propriety of deeming was "affirmed by an equally divided court. . . ." 8/ Although Judge Ross recognized that the district court had not "specifically rul[ed] on the validity of the [federal] regulation," Ross Op., at 4 (App. "A", at 6a), he also noted that "there is no dispute that the new [state] procedure approved by the district court is contrary to regulation, §435.723." Id., at 7 (App. "A", at 10a-11a). And Judge McMillian's opinion also assumed that the issue before the court was the propriety of the federal regulation. Thus, both sides of the Court of Appeals directed their attention primarily at a determination of whether the controlling federal regulation, 42 C.F.R. §435.723, was valid. This approach was undertaken despite the fact that the institution responsible for the regulation, HHS, was not a party to the action.

8/ Curiously, all eight members of the Court reversed the district court's decision forbidding consideration of government benefits because of the applicable "anti-alienation" provisions. Ross Op., at 19-20, McM. Op., at 56-57 (App. "A", at 28a, 74a). This action was peculiar since the defendants had not appealed that decision, nor had either party or HHS discussed that issue in their briefs to the Court of Appeals or at either oral argument.

Judge Ross views the applicable consideration as "whether the regulation is an incorrect interpretation of the statute [42 U.S.C.] §1396a(a)(17). . . ." Ross Op., at 7 (App. "A", at 11a). By contrast, Judge McMillian finds the question to be "whether the regulation is proper, not how the statutory term should be interpreted," and "whether the federal regulation itself is a reasonable interpretation of the statutory provision." McM. Op., at 22, 23 (App. "A", at 32a, 33a)(emphasis in original). Judge McMillian thus places considerably greater reliance on the interpretation of the Secretary, especially in light of the specific statutory provision directing the Secretary to prescribe the appropriate standards. 42 U.S.C. §1396a(a)(17)(B). McM. Op., at 23 (App. "A", at 32a). In any event, Judge McMillian, regardless of which standard is employed, concludes that the federal regulation is the more appropriate interpretation of the statute. McM. Op., at 23 (App. "A", at 33a).

The two opinions are also noteworthy because of the different approaches to the substantive issue which they employ. Judge Ross devotes his attention primarily to the Medicaid statute itself, especially 42 U.S.C. §1396a(a)(17). His reasoning depends on the impropriety, in his view, of HHS reading the "availability" language of 42 U.S.C. §1396a(a)(17) to mean "actually contributed." Ross Op., at 11 (App. "A", at 17a-18a). Furthermore, he notes that HHS "does not cite any SSI statute that dictates the 'actually contributed' language of the Medicaid regulation, 435.723." Id., at 14 (App. "A", at 22a) (emphasis in original). He refuses to accept the

connection between the SSI and Medicaid statutes, preferring to find the resolution of the question solely in section 1396a(a)(17). Id., at 15 (App. "A", at 23a. Finally, Judge Ross evidences considerable concern with the perceived fiscal effect of the federal regulations on states and taxpayers and with the alleged incentive which the federal regulations provide to non-instutitionalized spouses to ignore their responsibilities. Id., at 18, 21 (App. "A", at 26a-27a, 29a).

Judge McMillian, however, recognizes the pivotal link between the SSI statute and the Medicaid statute: "[T]he deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility." McM.Op., at 26 (App. "A", at 37a). He notes that integration of the SSI rules into the Medicaid situation is implicitly contemplated by the Medicaid statute's legislative history, and that the recognition of financial responsibility in 42 U.S.C. §1396a(a)(17)(D) is not repudiated by the HHS regulation, but is, rather, limited by it. Id., at 29-31 (App. "A", at 40a-42a). Judge McMillian analyzes in detail both the history of the Medicaid statute and the creation of the SSI program, and he evaluates the "link" between the two set out in 42 U.S.C. §1396a(a)(10)(A). He determines that the SSI rules on separation of spouses must be applied, and have been applied, by the comparable Medicaid regulations. Id., at 46-47 (App. "A", at 61a-62a). He brings together the different statutes and provisions by recognizing what Congress intended and what HHS has implemented: "In sum, Medicaid eligibility in

an SSI state is premised upon SSI eligibility." Id., at 49 (App. "A", at 65a).

The split decision of the Court of Appeals results in the affirmance of the district court despite the specific federal regulation mandating a contrary result. The effect is the invalidation of the federal regulation.

REASONS FOR GRANTING THE WRIT

THE EIGHTH CIRCUIT'S DECISION CONTRADICTS EXPLICIT CONGRESSIONAL INTENT, THE REASONABLE EFFORT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EFFECT THAT INTENT, AND NUMEROUS FEDERAL COURTS WHICH HAVE CONSIDERED THE MEDICAID-SSI RELATIONSHIP

The regulation which the Court of Appeals has invalidated, 42 C.F.R. §435.723, represents the determination by HHS as to the limitations on "deeming" which must exist under the Medicaid and SSI statutes in the so-called "SSI states." That the specific issue of "deeming" is itself an important one is readily apparent from the number of cases which have dealt with it.[9/]

[9/] See, e.g., the list of cases in Judge Ross' opinion, at 7-8 n.3 (App. "A", at 11a-13a n.3); see also Norman v. St. Clair, supra, 610 F.2d, at 1240 n.16.

Indeed, one state has now suggested that a conflict exists between the circuits on an aspect of the deeming issue in the "209(b) states." Brown v. Stanton, 617 F.2d 1224 (7th Cir. 1980), pet. for cert. filed No. 79-1690, 48 U.S.L.W. 3735 (April 25, 1980). But those cases, and other similar ones pending,[10/] are directed at a different issue -- a considerably more limited issue.

Their concern is with the issue of Medicaid deeming in the fifteen "209(b) states." The instant case, however, deals not only with the issue of Medicaid deeming in the remaining "SSI states," but, in addition, is concerned with perhaps the most important aspect of Medicaid eligibility. That aspect, the subject of this petition, is whether the eligibility conditions of the SSI statute necessarily apply to determinations of Medicaid eligibility for the aged, blind and disabled in those 35 jurisdictions. If the Eighth Circuit decision is allowed to stand, all prior assumptions as to the integration of Medicaid and SSI eligibility conditions will be undermined. Indeed, the decisions of virtually every court which has considered the issue will be suspect. Given the chaotic results which the Court of

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10/ Allen v. Califano, No. C-78-0212 (D. Utah, Aug. 22, 1979), appeal pending No. 79-2167 (10th Cir.); Gray Panthers v. Secretary, Dept. of H.E.W., 461 F.Supp. 319 (D.D.C. 1978), appeal pending No. 79-1334 (D.C. Cir., argued Jan. 15, 1980).

Appeals' decision could engender, it is imperative that that decision be explicitly overruled. Otherwise, other states, like Iowa, will act with impunity towards those Medicaid regulations with which they disagree. This case, therefore, has implications well beyond the issue of deeming; as significant as that issue itself may be, a considerably more important one is raised by the Eighth Circuit's resolution of this case.

The critical issue in this case, unlike in the 209(b) deeming cases, is not the appropriate interpretation of "availability," but the proper evaluation of the integration of the two statutes. Congress specifically left it to the Secretary to define "availability." 42 U.S.C. §1396a(a)(17)(B). While that task may occasion a complex analysis for the 209(b) states, the interpretation in this context is controlled by another provision of the statute, 42 U.S.C. §1396a(a)(10), which leads directly to only one result. As Judge McMillian notes: "[T]he deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility." McM.Op., at 26 (App. "A", at 37a)(emphasis supplied).

The mandate and reference to the SSI eligibility criteria appears in §1396a(a)(10). The impact of that section is to require that all SSI eligibles be eligible for and receive Medicaid. The provision states that:

> "A State plan for medical assistance must -- . . . (10) provide -- (A) for

> making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI . . . or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter. . . ." 42 U.S.C. §1396a(a)(10)(A).

The controlling provision, therefore, twice notes the connection between SSI eligibility and Medicaid eligibility.

Congress' intent with this section should be obvious. Because of the Eighth Circuit's deviation, however, it is necessary to conclusively demonstrate that the courts and HHS have consistently understood this section to require that all SSI eligibles be eligible for and receive Medicaid. In a number of cases discussing various aspects of the relationship between SSI and Medicaid, the impact of SSI eligibility on Medicaid eligibility has been repeatedly spelled out. Those cases indicate the degree of the Eighth Circuit's departure from the universally accepted interpretation of the law. Caldwell v. Blum, ___ F. 2d ___, CCH Medicare & Medicaid Guide, par. 30,452 (2d Cir. 1980),[11] stay denied No. A946,

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[11] Congress "amended §1396a(a)(10) to state expressly (as it does now) that states must provide medical assistance to SSI recipients. Pub. L. No. 93-233, §13 (1973)." CCH Medicare & Medicaid Guide, par. 30,453, at 9759.

___ U.S. ___, 100 S.Ct. 1635 (1980) (Marshall, J.),[12] stay again denied, ___ U.S. ___, 48 U.S.L.W. 3785 (June 2, 1980) (en banc); Norman v. St. Clair, supra; Fabula v. Buck, supra;[13] Friedman v. Berger, 547 F.2d 724 (2d Cir. 1976), cert. denied 430 U.S. 984 (1977);[14] Hayes v. Stanton, 512 F.2d 133 (7th Cir. 1975); Gray Panthers v. Dept. of H.E.W., supra;[15]

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[12] "Any State which participates in Medicaid must extend medical benefits to all persons receiving supplemental security income (S.S.I.) benefits. . . . Such persons are known as the 'categorically needy.'" 100 S.Ct., at 1636.

[13] "[T]he Social Security Act requires that all SSI recipients be included in the state's Medicaid program and the transfers [of assets] could not affect SSI eligibility." 598 F.2d, at 874 n.13.

[14] "Aged, blind, and disabled patients whose personal incomes are low enough to qualify under the SSI program are considered 'categorically needy' and must be included within any state plan, 42 U.S.C. §1396a(a)(10)(A)." 547 F.2d, at 726 (footnote omitted).

[15] "The thirty-four states and the District of Columbia which automatically provide Medicaid assistance to recipients of Supplemental Security Income ['SSI'] are now specifically required to use the SSI rule on availability of income." 461 F.Supp., at 321.

Manfredi v. Maher, 435 F.Supp. 1106 (D. Conn. 1977);[16] West v. Cole, 390 F.Supp. 91 (N.D. Miss. 1975).[17]

Indeed, the very purpose of the "209(b)" option, which is codified at 42 U.S.C. §1396a(f), was to provide states with an opportunity to avoid the requirement that all SSI eligibles automatically be eligible for Medicaid. Congress was concerned that by forcing states to cover all SSI eligibles, their Medicaid roles might be increased so extensively that some states would decide not to participate in Medicaid at all. See Norman v. St. Clair, supra, 610 F.2d, at 1235; Hayes v. Stanton, supra, 512 F.2d, at 137-138; Gray Panthers v. Secretary, Dept. of H.E.W., supra, 461 F.Supp., at 321; West v. Cole, supra, 390 F.Supp., at 98-99 and nn. 5, 6. Thus, the legislature provided a method to avoid the strict

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16/ "In 35 of the 50 states, the issues before the Court could be resolved by a simple reference to extant regulations and case law authorities. In such states, Medicaid eligibility is linked directly to the criteria used in determining eligibility for the underlying categorical assistance programs. . . ." 435 F.Supp, at 1112.

17/ "Congress amended the Medicaid Act at 42 U.S.C. §1396a(a)(10) to expressly require all states to provide Medicaid assistance to all SSI beneficiaries." 390 F.Supp., at 98.

requirement that all SSI eligibles be covered. But Iowa did not take that option.

Not surprisingly, therefore, HHS saw its task after the passage of SSI as insuring that the SSI rules were imposed on the SSI states for Medicaid eligibility determinations. Thus, when it first proposed the regulations which became those here invalidated, HHS noted that its purpose was to set "forth the rule for use of SSI policy in determining the availability of the income and resources of spouses and parents for aged, blind, and disabled applicants in States using title XVI eligibility criteria." 40 Fed. Reg. 60074, 2d col. (Dec. 31, 1975). That was all the agency was ever attempting to do. Later, when the final regulations were published, it noted:

> "The new regulations require States to use title XVI availability criteria where Medicaid is provided to all supplemental security income recipients, as is already called for in section 1902(a)(10) of the Act." 43 Fed. Reg. 2685, 1st col. (Jan. 13, 1977)(emphasis supplied).

In short, HHS was only trying to set out in detail what was already called for in the statute.

It should, therefore, be indisputable that an SSI cash recipient must have the SSI eligibility conditions applied to her in determining Medicaid eligibility. In addition, there are individuals who are SSI eligible and therefore categorically needy, but who do not actually receive SSI cash benefits. Many nursing

home residents are in this category, for the SSI cash assistance level for the institutionalized is only $25 per month. 42 U.S.C. §1382(e)(1)(B); see McM.Op., at 47-48 (App. "A", at 63a). In order to ensure, however, that this low level would not preclude them from obtaining necessary Medicaid coverage, Congress extended categorical coverage to the aged, blind, and disabled beyond those who actually receive cash assistance. 42 U.S.C. §1396a(a)(10)(C)(III); 42 C.F.R. §§435.211, 435.231. This was accomplished by allowing states to set a higher SSI eligibility level of up to 300% of the normal SSI level. 42 U.S.C. §1396b(f)(4)(C). As Judge McMillian described it: "[T]he use of a higher income level for institutionalized individuals is based upon a fictitious optional state supplement where no benefits are actually paid or received by the institutionalized individual." McM.Op., at 49 (App. "A", at 65a).[18] Thus, individuals who would

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[18] This extension of coverage to the instututionalized was part of a larger effort to include certain people whose Medicaid eligibility Congress sought to encourage, but did not wish to mandate. Thus, those individuals not eligible for federal SSI benefits, but to whom states were encouraged to provide optional state supplement benefits because of the savings which states accrued by the federal government's take-over of the welfare program for the aged, blind and disabled, provided the theoretical basis for the creation of the "optional categorically needy." See 42 U.S.C. §1382e; 42 C.F.R. §435.230; see McM.Op., at 36-37 (App. A, at 49a-50a). Congress built on this extension of categorically needy coverage to create other optional groups, such as the institutionalized.

otherwise have not been eligible for Medicaid are classified with other SSI eligibles. As the decision below points out, Iowa took this limited option (as opposed to the broader and more expensive coverage of a medically needy program), and was using a $600 per month SSI level for institutionalized people as of July 1, 1979. McM. Op., at 49 (App. "A", at 65a). 19/

The creation of the optional categorically needy represented an effort to allow states to provide Medicaid to institutionalized people and others who would otherwise not have been eligible while at the same time not forcing states to develop a medically needy program in order to include these individuals.

> "This Committee bill therefore allows a State to deem an institutionalized person in need of a supplementary payment if his income is within 300 per cent of the SSI benefit level applicable to a non-institutionalized individual with no other income. . . . This [300%] limitation would be the same nationwide, and so would treat all States equitably, would allow most nursing home recipients to be covered,

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19/ Mrs. Herweg herself was, or should have been, SSI eligible as a cash assistance recipient, since her lack of any income whatsoever placed her below the $25 per month level for SSI cash assistance. McM. Op., at 56 (App. "A", at 73a).

and yet would assure that nursing home patients would be reasonably in need when compared to other Medicaid eligibles. . . ." S. Rep. No. 93-553, 93d Cong., 1st Sess. (1973), at 58.

The purpose of the optional groups indicates that they are to be considered like any other categorical group. Section (10)(A) itself applies to those "receiving aid or assistance under any plan of the State approved under subchapter XVI," and is thus not limited only to those actually receiving cash benefits. Moreover, the structure of the optional categorically needy indicates that Congress viewed then as an offshoot of the cash-assistance categorically needy, and subject to no different conditions. Congress was attempting to secure for the optional categorically needy the same rights as cash recipients had. As Judge McMillian recognized: "[T]he classification 'optional categorically needy' allows the states to selectively extend Medicaid coverage to individuals who are otherwise eligible to receive cash assistance but [are] not actual recipients." McM. Op., at 39 (App. "A", at 53a)(emphasis in original).[20/]

[20/] Further recognition of the non-cash recipient SSI eligibles as categorically needy is provided in 42 U.S.C. §1396a(a)(14). That section explicitly lumps the non-cash recipients in with the cash recipients in paragraph (A), thus precluding imposition of the co-payment on these individuals, while also explicitly indicating in paragraph (B) that the non-cash recipient SSI eligibles are not to be included with the medically needy on whom co-payments can be imposed.

In any event, subsection (10)(C) ensures that no more restrictive eligibility conditions are applied to any optional coverage group than are applied to those mandatorily covered. As HHS noted in the comments to these regulations:

> "[Section (10)(C)(i)] means that while a State might use more generous maintenance amounts in determining financial eligibility (i.e., medically needy levels, optional State supplementary payment levels, disregards or asset exemptions), all other SSI eligibility criteria are to be used." 42 Fed. Reg. 2685, 1st col. (Jan. 13, 1977).

Indeed, every court but one has agreed that the medically needy cannot have more restrictive eligibility conditions applied to them than are applied to the categorically needy.[21/] It would be illogical and inequitable to require the same eligibility conditions for the cash recipient categorically needy and the medically needy, while allowing more restrictive conditions for the

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21/ See, e.g., Caldwell v. Blum, supra, CCH Medicare & Medicaid Guide, par. 30,453, at p. 9759, and cases cited therein at n. 8; Fabula v. Buck, supra, 598 F.2d, at 872-873; Hendrickson v. Noot, ___ F. Supp. ___, CCH Medicare & Medicaid Guide, par. 30,499, at p. 9920 (D. Minn. 1980). Contra, Dawson v. Myers, ___ F.2d ___, CCH Medicare & Medicaid Guide, par. 30,501, at p. 9927 (9th Cir. 1980), pet. for rehearing pending.

optional categorically needy. It was Congress' intention that no potential Medicaid recipients should be subject to more restrictive eligibility conditions than the cash recipient categorically needy had applied to them. The new regulations merely sought to effect that goal, so that all aged, blind, and disabled applicants for medical assistance would be subject to the same eligibility conditions.

Once that point is recognized, the action of HHS must be viewed as appropriate. The agency has ensured that all SSI eligibles will be eligible for Medicaid by inserting the SSI eligibility rules for deeming into the Medicaid regulations applicable to the SSI states. Thus, Judge Ross' insistence that HHS can "cite[] no SSI statute which demands the use of the term 'actually contributed' in the current regulation," Ross Op., at 15 (App. "A", at 23a), a factor on which he appears to place great significance, is irrelevant. Indeed, there is no such language, but the SSI statute details that, after the spouses separate, deeming must cease immediately when one spouse is not eligible for SSI, 42 U.S.C. §1382c(f)(1),[22] and after six months when both spouses are

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[22] For administrative reasons, recognition of the separation and thus the cessation of deeming cannot be effected until the end of the calendar month in which they separate. McM. Op., at 44 (App. "A", at 59a).

eligible. 42 U.S.C. §1382c(b).[23] After the relevant periods of separation, the spouses are treated as separate economic units by the SSI statute, and they must therefore be similarly treated under the Medicaid regulations.

The regulations accomplish that. They track the SSI statute. As Judge McMillian noted:

> "These [SSI] periods of deeming should be familiar to the reader; they are precisely the periods of deeming specified in the Medicaid regulation at issue, 42 C.F.R. §435.723. This congruence is not coincidental; it is compelled by the relationship between the SSI and the Medicaid programs." McM.Op., at 46 (App. "A", at 61a-62a).[24]

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[23] The treatment of physically separated spouses as one couple for six months after separation, when both are eligible, represents a congressional desire to discourage fraudulent separations; because an SSI couple's benefit is lower than two separate benefits, see 42 U.S.C. §§1382(b)(1), (2), the statute defined a couple separated for less than six months as if the spouses were still living together. 42 U.S.C. §1382c(b) (definition of "eligible spouse"). See H.Rep.No. 92-231, 92d Cong., 2d Sess. (1972), reprinted in [1972] U.S. Code Cong. & Admin. News, 5136.

[24] For a more complete discussion of how the SSI statute on this point is structured, see McM.Op., at 40-46 (App. "A", at 54a-61a).

The action of the Eighth Circuit in affirming the district court thus invalidates an HHS regulation which was specifically written to effect an explicit congressional intention of tying Medicaid eligibility to SSI eligibility in the SSI states. Congress wrote the Medicaid statute so that the aged, blind and disabled applying for medical assistance would have the same eligibility conditions applied to them as were applied under the SSI statute. Congress gave states the options of including the medically needy and certain categorically needy. But it did not intend for different rules to be applied among those categories. That option was provided only in 42 U.S.C. §1396a(f). If a state chose to be an SSI state, it was tied into the SSI eligibility conditions.

The courts have consistently recognized that the was the proper interpretation of the interrelationship of the two statuts. HHS attempted to spell out these requirements in this deeming context through the challenged regulation; it was not only a reasonable effort to effect Congress' intent, but it was virtually the only way to ensure that SSI eligibles were subject to the SSI eligibility conditions in this situation.[25/] The Eighth Circuit, however, has ignored the congressional intent,

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25/ In the only decision considering the validity of state deeming regulations in an SSI state, the issue of the propriety of these federal regulations was not a factor. Griswold v. Page, TCA 77-0712 (N.D. Fla. 1977), reported at CCH Medicare & Medicaid Guide, par. 28,537.

has repudiated HHS' effort to effect that intent, and has contradicted numerous other courts which have recognized the integration of SSI and Medicaid eligibility. The decision below thus has the potential for encouraging other states to ignore HHS regulations which they find not to be in their "best interests."

Judge Ross has supported his analysis by noting that the "rigid and costly imposition of unreasonable SSI regulations [are] inappropriate and unfair to the taxpayer and welfare recipients of the state." Ross Op., at 18 (App. "A", at 27a). In short, he and other judges object to the burden which the regulation allegedly places on Iowa. Any burden, however, has been placed there not by the regulations, but by Congress. HHS was merely undertaking to implement a congressional directive.

Iowa had, and still retains, options under the Medicaid statute which might assuage its dissatisfaction. It can drop coverage of the optional categorically needy, or it can seek 209(b) status, which might free it from the "rigid . . . imposition of unreasonable SSI regulations." Congress has given the states considerable flexibility to contour their Medicaid programs to meet their respective needs. If a state still feels that there is too much rigidity, it should seek to amend the statute.

It is not a court's function, however, to rewrite a statute to provide flexibility where Congress intended none. Those changes, if any, must come from that latter body. "[I]ssues

of legislative policy . . . [are] better addressed to the wisdom of Congress than to the judgment of this Court." Miller v. Youakim, 99 S.Ct. 957, 968 n.21 (1979), quoting Marquette National Bank v. First of Omaha Service Corp., 99 S.Ct. 540, 550-551 (1978). It is improper for a Court of Appeals to fashion a decision which is plainly antagonistic to the statutory framework and which ignores settled and explicit law. States should not be encouraged to disavow federal directives merely because the states are dissatisfied with the policy.

The Eighth Circuit has abetted Iowa's scheme to ignore its obligations under the controlling federal scheme. In so doing, it has established a precedent which ranges far beyond the immediate confines of the deeming issue and which throws considerable doubt onto the integration of Medicaid and SSI.

CONCLUSION

For the reasons presented above, a writ should issue to review the decision of the Eighth Circuit.

Respectfully submitted,

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DATED: July, 1980

APPENDICES

APPENDIX A

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 78-1664

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg, and Darrell E. Herweg, and all others similarly situated,	*	
Appellants,	*	Appeal from the United States District Court for the Southern District of Iowa.
v.	*	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, and Kevin J. Burns, individually and in his capacity as Commissioner of the Iowa Department of Social Services,	*	
Appellees.	*	

Submitted: September 10, 1979

Filed: March 18, 1980

Before GIBSON, Chief Judge,* LAY, HEANEY, BRIGHT, ROSS, STEPHENSON, HENLEY, and McMILLIAN, Circuit Judges.

*The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was

(cont. p. 2a)

ORDER

Pursuant to the attached opinion, the judgment of the district court is affirmed by an equally divided court, except that portion relating to the sources of income the state may consider as available to Medicaid applicants and recipients, which is reversed and remanded.

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* (cont.)
submitted and took senior status on December 31, 1979, before the opinion was filed.

United States Court of Appeals

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*The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was

(cont. p. 4a)

ROSS, Circuit Judge.

Elvina M. Herweg and her husband, Darrell E. Herweg, individually and as representatives of a class, appeal a decision by the district court[1] making Medicaid eligibility determinations affecting the Herwegs and the class. The district court, in January 1978, enjoined the state of Iowa from determining Medicaid eligibility by "deeming," through the use of an arbitrary formula, the income of a noninstitutionalized spouse as available to the institutionalized spouse. Herweg v. Ray, 443 F. Supp. 1315, 1320 (S.D. Iowa 1978).

Later, upon request of the parties, the district court defined the contours of relief it decided to be appropriate. Based on the relevant Medicaid statute, 42 U.S.C. § 1396a(a)(17) the district court disapproved deeming by an arbitrary formula but approved Iowa's use of a factual determination in each case as to the amount the state could consider as available from the noninstitutionalized spouse for the care of the institutionalized spouse. Herweg v. Ray, Civil No. 77-222-1, slip op. at 3 (S.D. Iowa July 10, 1978). Appellants, however, contend that this solution violates Medicaid statutes and regulations. They argue that Medicaid eligibility must be determined only on the basis of

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* (cont.)
submitted and took senior status on December 31, 1979, before the opinion was filed.

[1] The Honorable W. C. Stuart, Chief Judge, United States District Court for the Southern District of Iowa.

contributions actually made by the noninstitutionalized spouse to the institutionalized spouse's care. They further argue that if the spouse does not actually contribute, even though financially able, the state should determine that the institutionalized spouse is eligible and make full payment of benefits. Then if it desires, the state could sue the financially responsible spouse under its relative responsibility law.

Because the district court invalidated Iowa's "deeming" procedure on statutory grounds the constitutional claims of the plaintiffs were not reached. Herweg v. Ray, supra, 443 F. Supp. at 1320. Those claims allege that "deeming" violates the due process clause and the equal protection clause by creation of an irrebuttable presumption and an arbitrary classification.

Before addressing the issues raised by appellants, we will review Iowa's prior "deeming" procedures as applied to the Herwegs' situation.

Since August 1976, 47 year old Elvina Herweg has been in a comotose state which resulted from two cerebral hemorrhages. Mrs. Herweg was placed in a long-term care facility in November 1976.

Darrell Herweg was employed as a butcher when this action was instituted and his gross monthly income was $1,350 (net $1,032). The Herwegs have three teenage daughters at home.

In January 1977, Mr. Herweg applied for Medicaid assistance for his wife. Mrs. Herweg

was found eligible for Medicaid and Mr. Herweg was required to pay $234.80 per month toward his wife's medical expenses which were approximately $1,374 per month. The "deemed" amount, $234.80 per month, was arrived at by use of a formula which excluded half of Mr. Herweg's earned income and then excluded standard living allowances for Mr. Herweg and the children at home. Standard exclusions for work expenses and the personal needs of the institutionalized spouse were also allowed.

In June 1977, apparently upon advice from HEW, the state of Iowa's formula for determining eligibility was changed in that one-half of Mr. Herweg's earned income was not excluded. This change resulted in a determination that Mrs. Herweg was no longer eligible for Medicaid and led to the filing of this suit. After the district court granted a temporary restraining order, the state again changed the formula to exclude one-half of Mr. Herweg's earned income. Mrs. Herweg was again determined eligible for Medicaid and based on increased living allowance exclusions, $150.30 of Mr. Herweg's monthly income was deemed available for Mrs. Herweg's medical expenses.

The district court held that the state of Iowa's method of "deeming" through the use of an arbitrary formula conflicted with 42 U.S.C. § 1396a(a)(17) and the applicable regulations 45 C.F.R. 248.3(b)(a)(ii) (currently, 42 C.F.R. 435.723(d)(1978)). Id. at 1320. However, without specifically ruling on the validity of the regulation, the district court found that under the statute,

42 U.S.C. § 1396a(a)(17) the state should be allowed to make a factual determination of actual income and expenses of the noninstitutionalized spouse and determine a reasonable amount to require as a contribution. Id. at 1320. The state of Iowa submitted to the district court proposed procedures for making such a factual determination in each case and the district court approved the state's new procedures as entirely consistent with federal law.

It is important to note that the state of Iowa is not challenging the district court's determination that "deeming" through the use of an arbitrary formula is contrary to § 1396a(a)(17). Rather, the conflict involved in this appeal is the method the state of Iowa now uses, which is a factual determination of income actually received and expenses necessarily incurred, to determine the amount of money a state may require as a contribution from the noninstitutionalized spouse who is reasonably able to pay some of the medical expenses of his Medicaid eligible, institutionalized spouse.

The district court certified the class, as requested by plaintiffs, as including instances where the institutionalized spouse is eligible for Medicaid.[2] However, it is clear that the procedures plaintiffs challenge involve the method

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[2]The district court certified the class as consisting of "all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid

(cont. p. 8a)

used to calculate the institutionalized spouse's available income. This same calculation is used not only when determining the amount of the required contribution as in the case of the Herwegs, but also in determining initial eligibility for Medicaid. Therefore, our concern in this case must of necessity focus on not only the application of the procedure to one who is eligible for Medicaid but also the application of the procedure to one who seeks Medicaid eligibility but whose income and expenses may justify the denial of eligibility under the statute.

Jurisdiction

In view of the recent Supreme Court decision in Chapman v. Houston Welfare Rights Organization, 441 U.S. 600 (1979), a brief review of jurisdiction is necessary. Chapman involved a challenge to state welfare regulations based solely on the grounds that the regulation conflicted with the Social Security Act. The Supreme Court indicated that "an allegation of incompatibility between federal and state statutes and regulations does not, in itself, give rise to a claim 'secured by the Constitution' within the meaning of

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2 (cont.)
and requires institutionalization; and (2) the other spouse is not institutionalized and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse." Herweg v. Ray, 443 F. Supp. 1315, 1320 (S.D. Iowa 1978).

[28 U.S.C.] § 1343(3)." Id. at 615. The Court also rejected the argument "that § 1983 is an Act of Congress 'providing for equal rights' within the meaning of §1343(3)" or a "statute 'providing for the protection of civil rights, including the right to vote'" within the meaning of § 1343(4). Id. at 617-18. The Supreme Court then held that "[t]he Social Security Act does not deal with the concept of 'equality' or with the guarantee of 'civil rights,' as those terms are commonly understood." Id. at 621. Therefore, the Social Security Act is not included within the meaning of §1343(3) or (4). Id. at 621. However, neither Chapman nor the case with which it was consolidated on review, Gonzales v. Young, involved any constitutional claims other than a basic supremacy clause challenge. Further, the Supreme Court specifically noted that "[w]here the underlying right is based on the Constitution itself, rather than an Act of Congress, § 1343(3) obviously provides jurisdiction." Id. at 618 n. 36. The Supreme Court in Chapman did not alter its previous decision in Hagans v. Levine, 415 U.S. 528 (1974). In Hagans, the Supreme Court approved the review of a statutory conflict claim under a pendent jurisdiction rationale where the district court had found a substantial constitutional question presented. Id. at 536. The Supreme Court also noted that:

> A [constitutional] claim is insubstantial only if '"its unsoundness so clearly results from the previous decisions of this court as to foreclose the subject and leave no room for the inference that the questions sought to

to be raised can be the subject of controversy."'

Id. at 538 (citations omitted).

In the present case, the complaint alleged a violation of the due process clause, in that "deeming" constitutes an irrebuttable presumption not rationally related to a legitimate state interest. The plaintiffs also raised an equal protection claim regarding different treatment of married versus unmarried Medicaid recipients.

Although the district court specifically did not reach the constitutional claims, we hold that the claims present substantial constitutional questions. Thus, the district court possessed pendent jurisdiction over the statutory issues based on its proper jurisdiction over the constitutional claims under § 1983 and § 1343(3).

The Medicaid Statute

The district court found that Iowa's "deeming" procedure was contrary to both the relevant statute § 1396a(a)(17) and the relevant HEW regulation 45 C.F.R. § 248.3(b) [currently 42 C.F.R. § 435.723 (October 1, 1978)]. Herweg v. Ray, supra, 443 F. Supp. at 1320. However, the district court also found that "deeming" income to be unavailable unless actually contributed, as required by the regulation, "seemed" contrary to congressional intent. Id. at 1320. Thus, the district court approved the state of Iowa's new procedure for making a reasonable evaluation as consistent with § 1396a(a)(17). However, there

is no dispute that the new procedure approved by the district court is contrary to regulation, § 435.723. Therefore, the issue this court must face is whether the regulation is an incorrect interpretation of the statute, § 1396a(a)(17), thus justifying the result reached by the district court. Other courts have consistently struck down "deeming"; however, the courts have varied or been unclear on the method the state may then use to enforce financial responsibility.[3] But see

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[3] Decisions which allow the state to make a reasonable evaluation:

Norman v. St. Clair, Nos. 77-1722, 79-2471 (5th Cir. Jan. 28, 1980) (approving "deeming" but ordering that "deeming" be done in a flexible manner taking into account the "expenses necessary for the spouse to live in the community" slip op. at 2714); Gray Panthers v. Secretary of HEW, 461 F. Supp. 319, 323 (D.D.C. 1978), appeal docketed, No. 79-1334 (D.C. Cir. March 27, 1979) (citing Herweg with approval and approving consideration of spouse's income by reasonable standards); Franssen v. Juras, 406 F. Supp. 1375, 1379 (D. Ore. 1975) (barring deeming under old HEW regulation and allowing state to make a reasonable evaluation of income or reenact a relative responsibility law).

Decisions which contain language which would appear to allow the state to make a reasonable evaluation:

(cont. p. 12a)

Norman v. St. Clair, Nos. 77-1722, 79-2471 (5th Cir. Jan. 28, 1980) and discussion, infra, at 17, n. 6.

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3 (cont.)

Rubin v. Creasy, No. C-1-78-810, slip op. at 17-18 (S.D. Ohio April 13, 1979) (temporary restraining order citing Herweg with approval and barring deeming of resources without a factual finding of actual availability); Foard v. Gibson, C-C-78-0319, slip op. at 4 (W.D. N.C. March 29, 1979)(barring "deeming" practices which disregard the actual living costs of the noninstitutionalized spouse); Burns v. Vowell, 424 F. Supp. 1135, 1141 (S.D. Tex. 1976) (preliminary injunction barring deeming under old HEW regulation as to named plaintiffs; court indicated that income of a noninstitutionalized spouse can be considered through the application of reasonable standards).

Decisions which do not indicate what recourse, if any, the state has for enforcing financial responsibility:

Allen v. Califano, No. 78-0212, slip op. at 2 (D. Utah August 23, 1979) (barring "deeming" of income which is not in fact available); Griswold v. Page, TCA 77-0712, slip op. at 6-7 (N.D. Fla. May 20, 1977) (barring "deeming" by state as of effective date of the new HEW regulation); Krygier v. Buscaglia, Civ-78-83, slip op. at 8 (W.D.N.Y. May 2, 1979), stay pending appeal, No. 79-7386 (2d Cir. July 17, 1979) (district court preliminarily

(cont. p. 13a)

In undertaking this review, we recognize that "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong ***." Beal v. Doe, 432 U.S. 438, 447 (1977); New York Dept. of Soc. Services v. Dublino, 413 U.S. 405, 421 (1973); Red Lion Broadcasting Co. v. FCC, 395 U.S. 367, 381 (1969). "But the courts are the final authorities on issues of statutory construction

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3 (cont.)

enjoined enforcement of state "deeming" regulation unless a hearing is first affored to the noninstitutionalized spouse).

Decisions which allow the state to use only its relative responsibility laws to enforce financial responsibility:

Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980) ("proper method of enforcing spousal responsibility is through state spousal support statutes" slip op. at 14); Hanke v. Nyhus, 470 F. Supp. 742, 746 (D. Minn. 1979) and Advisory Council v. Kelly, 470 F. Supp. 747, 752 (D. Minn. 1979) (court found that accumulated property [rather than income] of noninstitutionalized spouse was not available unless it was contributed; however, state could pursue claim for contribution under its relative responsibility laws); Manfredi v. Maher, 435 F. Supp. 1106, 1115 n.18 (D. Conn. 1977) (barring deeming and allowing state to enforce its relative responsibility laws).

and 'are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute.'" (Citations omitted.) Volkswagenwerk v. FMC, 390 U.S. 261, 272 (1968).

42 U.S.C. § 1396a(a)(17) provides in pertinent part:

> (a) A State plan for medical assistance must--
>
> (17) include reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient * * * (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 * * *.

(Emphasis supplied.)

The legislative history of § 1396a(a)(17) is set out in S. REP. No. 404, 89th Cong., 1st Sess. 4, reprinted in [1965] U. S. CODE CONG. & AD. NEWS 1943, 2018:

> Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.
>
> The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives.

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

(Emphasis supplied.)

We note that although a state may not "assume the availability of income," Congress did specify that state "requirements for support may reasonably include the payment by [a spouse], if able, for medical care." However, "States may not include * * * provisions for requiring contributions from relatives other than a spouse * * *." But, "contributions actually made by relatives or

friends * * * will be taken into account * * *."

In contrast, the relevant regulation 42 C.F.R. § 435.723 (October 1, 1978) indicates:

> § 435.723 Financial responsibility of spouses.
>
> (a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in determining eligibility of aged, blind and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.
>
> * * * *
>
> (d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

(Emphasis supplied.)

It is interesting to note that earlier HEW interpretation of § 1396a(a)(17) directly followed the statute. Those regulations 45 C.F.R. 248.3(b)(1) (October 1, 1975) stated "that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated." We find that the term "available" in § 1396a(a)(17) when read in conjunction with the

legislative history cannot by any stretch of the imagination be translated into the "actually contributed" language of the current regulation. We find that HEW's interpretation of the statute is wrong. In effect it has substituted the words "actually contributed" for the statutory word "available." In our view, which is based partially on the legislative history quoted, the words "actually available" encompass funds which a spouse has available to contribute even though he or she does not actually contribute them to the spouse.

Furthermore, the statute specifically allows a state to consider the financial responsibility of a spouse in determining eligibility. Nothing in the statute or legislative history limits a state to enforcing this responsibility only through use of the state's relative responsibility law. We find that HEW's regulation nullifies the congressional intent of § 1396a(a)(17)(D), which indicates the financial responsibility of a spouse can be considered by a state.[4] Leave the state of Iowa

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[4]In Batterton v. Francis, 432 U.S. 416, 426 (1977) a narrower scope of review for HEW regulations was established in a situation where the statute "expressly delegated to the Secretary the power to prescribe standards for determining what constitutes 'unemployment' for purposes of AFDC-UF eligibility." Id. at 425. This narrower review would cause the regulation to be "set aside only if the Secretary exceeded his statutory authority or if the regulation is 'arbitrary, capricious, an abuse of discretion or otherwise

(cont. p. 19a)

to sue retroactively and periodically for payments the noninstitutionalized spouse could reasonably afford, is to us an inequitable and burdensome result requiring repeated lawsuits against the same person. Furthermore, we will not force Iowa to grant Medicaid eligibility to a person whose spouse is extremely wealthy but whose

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4 (cont.)

not in accordance with law.' 5 U.S.C. §§ 706(2)(A), (C)." Id. at 426.

However, subsection (D) of § 1396a(a)(17) must be read as a limitation on the Secretary's ability to prescribe standards for what constitutes "available" income under subsection (B) of the statute. Furthermore, in Batterton Congress had given HEW the specific task of defining one term, "unemployment," rather than the general delegation of establishing standards which are "consistent with the objectives of this subchapter." § 1396a(a)(17)(A). Specifically, the statute in Batterton "requires a participating State to provide assistance where a needy child 'has been deprived of parental support or care by reason of the unemployment (as determined in accordance with standards prescribed by the Secretary) of his father.' 42 U.S.C. § 607(a)." Id. at 419. In view of the difference in statutory mandate, we do not believe the standard of review under Batterton applicable to this case. However, even under the narrower test of Batterton, we would hold that the regulation must fall.

income cannot be considered (unless actually contributed) after the first month of institutionalization. In addition to the legality of the question, a contrary result would be most unfair to the noninstitutionalized spouse who does contribute what he can to the care of his spouse or to the taxpayers who pay for such care when they are not legally obligated to do so.

Both the Fifth Circuit in Norman v. St. Clair, Nos. 77-1722, 79-2471, slip op. at 2710 (5th Cir. Jan. 28, 1980) and Judge Pell in Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980) (dissenting in part) recognized the inevitable consequences of limiting a state's recourse to its relative responsibility laws. Judge Pell, in the course of an unusually short and cogent dissent stated:

> Under [that result], there is an open invitation for the spouse to decide that he or she does not wish to make the excess payment. In this era of inflation, and giving consideration to the human inclination not to pay out money when one doesn't have to, I think it reasonable to conclude that few would decline the invitation.

Slip. op. at 18.

The SSI-Medicaid Link

Upon request of the court, HEW filed an amicus brief concerning the validity of the regulation, § 435.723. HEW argues that there is a link between SSI (Supplemental Security Income) and Medicaid eligibility standards based on 42 U.S.C.

§ 1396a(a)(10)(A). Based on this link, HEW believes that an SSI statute, 42 U.S.C. § 1382c (f)(1) dictates that income be "deemed" for at least the first month of institutionalization where there is an ineligible noninstitutionalized spouse.[5]

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[5]HEW's brief considers at much greater length the validity of deeming for six months where there is an eligible couple under 42 C.F.R. § 435.723(c) but this subsection was not considered by the district court and we will not consider it here. However, it appears that the state of Iowa does not "deem" in the instance where both spouses are in such a low income bracket as to constitute an eligible couple. HEW justifies this six month "deeming" based on SSI provisions of 42 U.S.C. § 1382c(b) wherein an "eligible spouse" is one "who has not been living apart" from their eligible husband or wife "for more than six months." However, this six month rule was placed in the SSI statute to discourage eligible couples from voluntarily living separate in order to receive higher benefits. See Mansfield v. Weinburger, 398 F. Supp. 965, 969 (D.D.C. 1975). Additionally, a 1976 amendment to 42 U.S.C. § 1382(e)(1)(B)(ii), Pub. L. 94-566, § 502 shows a congressional desire to consider individually the finances of an eligible couple where one spouse is institutionalized. We can find no logic in "deeming" for a longer period of time where there is an eligible couple than where only one spouse is eligible.

However, HEW does not cite any SSI statute that dictates the "actually contributed" language of the Medicaid regulation, § 435.723.

42 U.S.C. § 1396a(a)(10)(A), the Medicaid statute, indicates that a state plan for medical assistance must:

> (10) provide--
>
> (A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

The SSI statute on which HEW bases its argument is 42 U.S.C. § 1382c(f)(1), which states:

> (f)(1) For purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

(Emphasis supplied.)

In response to HEW, appellants argue that the Medicaid statute, § 1396a(a)(17) does not allow any deeming, even for one month. Appellants state that the "SSI statute did not implicitly or explicitly alter the meaning and intent of the Medicaid provisions regarding availability." But appellants also state that if we reject their argument that § 1396a(a)(17) only allows actually contributed income to be considered, then appellants will agree with HEW that the SSI-Medicaid link justifies the current regulation.

We believe that the answer to this conflict lies in the language of § 1396a(a)(17), itself. Deeming by use of an arbitrary formula is not allowed. However, the statute does allow a reasonable evaluation of income available to the applicant or recipient, taking into account the financial responsibility of their spouse.

HEW, as previously indicated, cites no SSI statute which demands the use of the term "actually contributed" in the current regulation, 435.723, rather than the term used in the Medicaid statute (and previous HEW regulations) "available." The SSI statute HEW does cite, 42 U.S.C. § 1382c(f)(1) allows "deeming" by use of an arbitrary formula when an eligible person lives with their ineligible spouse. Apparently, HEW decided that where a couple does not live together (even involuntarily as in the institutionalized spouse's case) then the opposite of arbitrary "deeming" must apply--"actually contributed." However, this view fails to recognize the middle ground specifically provided for in § 1396a(a)(17) which the district court identified. That middle

ground is a reasonable evaluation of available income and expenses, which reasonable evaluation is also the opposite of arbitrary "deeming."

Additionally, the SSI statute, § 1382c(f)(1) provides that when an eligible spouse lives with her ineligible spouse, the eligible spouse's income is "deemed to include any income" of the ineligible spouse "whether or not available." Therefore, under the SSI statute there is no need to define the term "available"; its definition is essentially irrelevant. In contrast, the Medicaid statute, § 1396a(a)(17) demands that the standards drawn consider availability, thus, the effort to define "available" must be controlled by the Medicaid statute not the SSI statute.

Although Norman v. St. Clair, supra, and Brown v. Stanton, supra, involved § 209(b) states rather than an SSI-state such as Iowa, it appears that in Norman the Fifth Circuit reached essentially the same result as we do here, by reasoning from the SSI-states' situation to that of a "§ 209(b) state." The court in Norman in discussing the previously cited SSI statute, § 1382c(f)(1), indicates the following:

> Thus under certain circumstances Medicaid eligibility determinations in an "SSI state" must, because of the statutory mandate in the SSI legislation, take into account income that is deemed available, without regard to whether that income is actually contributed. Since this statutory mandate exists concurrently in the Medicaid law with the

> provision of 42 U.S.C. § 1396a(a)(17) directing that only income which is "available" be taken into account, it must be concluded that the income deemed to Medicaid applicants pursuant to provisions of law applicable to SSI states is available income. A concept of available income which includes income deemed to spouses in SSI states must also encompass income deemed[6] to spouses in the more restrictive programs of the § 209(b) states.

Slip op. at 2709-10.

There are also additional reasons for finding SSI eligibility requirements inapplicable to the institutionalized spouse situation. In the institutionalized situation there is a "gap," which as we will explain, has been closed by states such as Iowa, by electing to cover optional groups.

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[6]The Fifth Circuit in Norman reached the result that "flexible" deeming by the state is mandated under the statute. That result is essentially similar to our approval of a reasonable evaluation of income. The difference is basically semantics. We believe that the term "deeming" conotates the use of an arbitrary or standardized formula and thus we decline to characterize our result as "reasonable deeming."

Congress apparently linked SSI and Medicaid because a person who needs financial assistance to live (SSI) would naturally need financial assistance for medical care. However, under 42 U.S.C. § 1382(e)(1)(B)(i) the maximum SSI benefit payable to an institutionalized individual who does not have an eligible spouse is $300 per year or $25 per month reduced by nonexcluded income. Congress authorized this amount for institutionalized individuals "to enable them to purchase small comfort items not supplied by the institution." H.R.REP. No. 92-231, 92nd Cong., 2d Sess. 3, reprinted in [1972] U. S. CODE CONG. & ADM. NEWS 4989, 5136. However, since the $25 payment is reduced by nonexcluded income, it seems apparent that many institutionalized individuals would not be eligible for SSI benefits although they would be in dire need of Mdeicaid. This "gap" in the SSI-Medicaid scheme was remedied by providing that a state may provide Medicaid coverage to optional groups, including (1) those who are SSI eligible but do not receive benefits, 42 C.F.R. § 435.210; (2) those who are ineligible for SSI because of lower income standards used to determine eligibility for institutionalized individuals, but who would be SSI eligible if not institutionalized, 42 C.F.R. § 435.211; and (3) institutionalized individuals who are not SSI eligible but who have income below a certain level. 42 C.F.R. § 435.231 (federal funds are available only for those persons whose income is below 300 percent of the SSI individual benefit amount, 42 C.F.R. § 435.1005).

In the situtation where states such as Iowa elect to provide medical coverage to optional

groups, some of whom are not eligible to receive SSI benefits, we find the rigid and costly imposition of unreasonable SSI regulations inappropriate and unfair to the taxpayer and welfare recipients of the state. Each state is limited in the total amount its legislature will appropriate. If it is forced to pay the entire cost of institutionalizing a person whose spouse has more income than he reasonably needs, optional coverage will of necessity be reduced or eliminated in other areas.

AFDC Cases

Appellants also note that the Supreme Court has struck down state AFDC provisions which "deem" the income of a MARS (man assuming the role of spouse) as available to the family without a showing of actual contribution. Van Lare v. Hurley, 421 U.S. 338 (1975); Lewis v. Martin, 397 U.S. 552 (1970); King v. Smith, 392 U.S. 309 (1968).

Appellees, however, argue that these cases can be distinguished in that a MARS has no legal obligation of support. Appellants argue that although legal responsibility was an aspect of those cases, the Supreme Court's concern focused on the "actually available" language of AFDC regulations.

We agree with the state of Iowa that these cases are distinguishable in that no legal duty existed for the MARS to support or contribute to the family. The one exception to this absence of legal duty to support arose in Lewis v. Martin, 397 U.S. 552 (1970). In Lewis the state of California had passed a law which required a

MARS to make a financial contribution to the family. Id. at 553 n. 2. The Supreme Court rejected "deeming" of the MARS income even where there was a legal duty because "the likelihood of the MARS contributing his income to the children--even if legally obligated to do so--is sufficiently uncertain in the absence of the marriage tie, to prevent viewing him as a 'breadwinner' unless the bread is actually set on the table." Id. at 559.

The uncertainty of support presented in the MARS situation is simply not present in this case where the legal duty to support is created by marriage and by state statute, and the legislative history of § 1396a(a)(17) indicates that "[t]he committee believes it is proper to expect spouses to support each other * * *." Furthermore, the result reached by the district court--a reasonable evaluation--is less burdensome than the arbitrary "deeming" formula used to evaluate a MARS' income.

OTHER ISSUES: The district court found that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities should be excluded from the sources of income the state may consider available to Medicaid applicants and recipients. Herweg v. Ray, Civil No. 77-222-1, slip op. at 2 (S.D. Iowa July 10, 1978). However, we believe these payments should be considered as available and their inclusion would constitute a reasonable evaluation of income within the meaning of § 1396a(a)(17). Furthermore, if the state's only recourse is through use of relative responsibility laws then these payments, no matter how large,

could not be attached. See Philpott v. Essex County Welfare Board, 409 U.S. 413, 415-16 (1973).

The Result

Our concern in this case, as expressed earlier, is the situation confronting the state when the noninstitutionalized spouse has more income than necessary for his own needs but chooses not to contribute any money to his institutionalized spouse who has little or no income. Under these circumstances the result advocated by other members of the court would force the state to first grant Medicaid eligibility to the institutionalized spouse, or take away the right of the state to require a contribution, and then sue the noninstitutionalized spouse retroactively and periodically for monies already expended by the state. Such a result is to us not only burdensome on the state but is contrary to the congressional intent reflected in § 1396a(a)(17). Plaintiffs have argued that our result--a reasonable evaluation of available income--will lead to eviction of the institutionalized spouse when the noninstitutionalized spouse fails to contribute the required amount. However, at oral argument counsel for the state of Iowa indicated that no such evictions have taken place using the current method. If institutionalized spouses are declared ineligible or are required to make a partial contribution, as here, we believe the necessary contribution will be made by the spouse rather than permitting eviction. We also believe that many more persons would "choose" not to support their institutionalized spouses if permitted to do so by the HEW regulation and if the only recourse of a state was a possible suit for past due payments

at some time in the distant future. The practical effect of upholding the appellants' position would be unfair to spouses who are properly making their contributions, would be very costly to the state of Iowa and would result in the diminution of welfare benefits to other more worthy recipients in Iowa's other welfare programs.

Our result also will eliminate the possibility of a totally inconsistent and inequitable situation occurring when the wealthier spouse is institutionalized. If for instance, Mr. Herweg had been institutionalized, but continued to receive income of $1,032 per month while leaving Mrs. Herweg at home with little or no income, the result would be devastating. Individualized assessment of income would make Mr. Herweg ineligible for Medicaid. This would occur because under Medicaid regulation, 42 C.F.R. § 435.725, deductions for income for support of spouse and children are made after the initial eligibility decision. Furthermore, these deductions cannot exceed basic subsistence levels leaving the spouse at home in poverty. Plaintiffs at an earlier point in this litigation appeared concerned with this dichotomy. In correspondence between the parties contained in the record of the district court counsel for plaintiffs stated:

> If it is the institutionalized spouse with the greater income, a different kind of problem exists. * * * [C]ombining income will be advantageous to the couple; in fact, it is a virtual necessity if the non-institutionalized spouse is to continue to live in the same environment. * * *

> Whether you [state of Iowa] phrase it as combining or not, it is important that a procedure be developed whereby income from the wealthier institutionalized spouse flows directly to the non-institutionalized spouse so that she can meet reasonable and necessary expenses.

Conclusion

The judgment of the district court is affirmed except it is reversed as heretofore indicated as to the sources of income the state may consider as available to Medicaid applicants and recipients. The state of Iowa may continue to use the procedures for evaluation of income approved by the district court, but only until such time as HEW issues regulations which comport with the true meaning and intent of § 1396a(a)(17) as set forth herein.

Judges Gibson, Bright and Henley concur in this opinion.

McMILLIAN, Circuit Judge.

For the reasons discussed below, I am unable to agree with Judge Ross's opinion. In my view, both deeming according to an arbitrary formula and deeming according to a factual evaluation of received income and necessary expenses, as approved by the district court and Judge Ross's opinion herein, are impermissible.

Standard of Review

As an initial matter, I accord greater weight to the interpretation made by HEW in the regulation at issue (42 C.F.R. § 435.723) than Judge Ross does. The question before us is whether the regulation is proper, not how the statutory term should be interpreted. E.g., Batterton v. Francis, 432 U.S. 416, 424 (1977). "Ordinarily, administrative interpretations of statutory terms are given important but not controlling significance." Id. However, Congress in § 1396a(a)(17)(B) has expressly delegated to the Secretary of HEW the power to prescribe standards for determining what constitutes "available" income and resources. That provision states that a state plan must "provide for taking into account only such income and resources as are, determined in accordance with standards prescribed by the Secretary, available to the applicant" when determining Medicaid eligibility. 42 U.S.C. § 1396a(a)(17)(B) (emphasis added).

> In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect. A reviewing court is not free to set aside those regulations simply because it would have interpreted the statute in a different manner.

The regulation at issue in this case is therefore entitled to more than mere

> deference or weight. It can be set aside only if the Secretary exceeded his statutory authority or if the regulation is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

Batterton v. Francis, supra, 432 U.S. at 425-26 (case citations and footnotes omitted).

Thus, the question is whether the federal regulation itself is a reasonable interpretation of the statutory provision. Whether or not the federal regulation is less reasonable than the state's regulation is beside the point. Moreover, "[e]ven if this were a contest as to which is more reasonable, the federal regulation would prevail." Aitchison v. Berger, 404 F. Supp. 1137, 1149 (S.D.N.Y. 1975), aff'd without published opinion, 538 F.2d 307 (2d Cir.), cert. denied, 429 U.S. 890 (1976).

Factual Background

This case involves a dispute over the interpretation of the word "available" in one part of the Medicaid statute, 42 U.S.C. § 1396a(a)(17)(B). It also involves the relationship between that statutory provision and another, 42 U.S.C. § 1396a(a)(17)(D), and certain regulations promulgated by the Secretary of HEW, in particular, 42 C.F.R. § 435.723.

Unfortunately, "[s]ince the welfare statutes now rival the Internal Revenue Code in complexity, one interprets them with less than robust confidence."

Lynch v. Philbrook, 550 F.2d 793, 795 (2d Cir. 1977). "As program after program has evolved, there has developed a degree of complexity in the Social Security Act and particularly the regulations which makes them almost unintelligible to the uninitiated." Friedman v. Berger, 547 F.2d 724, 727 n.7 (2d Cir. 1976), cert. denied, 430 U.S. 984 (1977). This is particularly true in the present case, which required unraveling the relationship between two Social Security programs, Supplemental Security Income (SSI) and Medicaid. Moreover, an examination of case law reveals that the courts have been less than uniform in their analysis of deeming and related questions. Compare Brown v. Stanton, No. 79-1459 (7th Cir. Jan. 30, 1980), with Norman v. St. Clair, No. 77-1722 (5th Cir. Jan. 28, 1980).

Medicaid is a cooperative federal-state program established in 1965, in Title XIX of the Social Security Act (hereinafter the Act), 42 U.S.C. § 1396 et seq. The basic purpose of Medicaid is to enable each state, as far as practicable under the conditions in each state, to furnish medical assistance to certain needy persons whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C. § 1396; e.g., Beal v. Doe, 432 U.S. 438, 444 (1977); Hodgson v. Board of County Commissioners, No. 79-1665 (8th Cir. Jan. 9, 1980) (slip op. at 5 n.8). The Medicaid program is jointly financed by the federal and state governments and administered by the states.

States are not required to institute a Medicaid program, but if they choose to do so, they must

submit to the Secretary of HEW a satisfactory state plan, describing the nature and scope of the state's Medicaid program, which must fulfill all the requirements of the Act. 42 U.S.C. § 1396a(a)(1)-(40). The Secretary of HEW, through the Administrator of the Health Care Financing Administration, has promulgated various regulations which supplement the statutory provisions in providing the framework within which participating states must develop and operate their Medicaid programs. E.g., Gray Panthers v. Secretary of HEW, 461 F. Supp. 319, 320 (D.D.C. 1978), appeal pending sub nom. Administrator, Health Care Financing Administration v. Gray Panthers, No. 79-1334 (D.C. Cir. 1980). Within the federal guidelines established by the federal statutory provisions and regulations, each participating state in its state plan determines eligible groups, types and ranges of services, payment levels for services, and administrative and operating procedures. "Participating states must, however, provide five general categories of medical services to individuals classified as 'categorically needy' [see discussion below]: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and x-ray services; (4) skilled nursing facilities, family planning services and supplies; and (5) physicians services and supplies; and (5) physicians services." Norman v. St. Clair, supra, slip op. at 4 (emphasis in original, footnote omitted). States must comply with the federal guidelines in order to be entitled to grants of federal funds in partial reimbursement for their expenditures in providing medical assistance. E.g., Johnson's Professional Nursing Home, Inc. v. Weinberger, 490 F.2d 841, 842-43 (5th Cir. 1974); Hanke v. Nyhus, 470 F. Supp. 742, 744 (D. Minn. 1979).

The statutory provision at issue provides in part that a state plan must

> include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient, . . . (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse. . . .

42 U.S.C. § 1396a(a)(17)(A)-(D). The Secretary of HEW has promulgated a regulation, 42 C.F.R. § 435.723(d), which interprets "available" to mean "actually contributed" in the case of couples separated by institutionalization. This regulation provides:

> If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together.

I do not agree that the Secretary's interpretation of the statutory term "available" is inconsistent with the statute or Congressional intent. As discussed below, the deeming regulation is based upon SSI eligibility criteria and is mandated by the Medicaid statute itself, which defines Medicaid eligibility by referring to SSI eligibility.

Arguments of the Parties

As I understand the arguments of appellants and the state of Iowa, neither party argues that the Secretary has exceeded her authority in promulgating this regulation. Such an argument would be of doubtful merit in view of the broad empowering provision of the Social Security Act, 42 U.S.C. § 1302, and the "reasonably related" standard of review. E.g., Johnson's Professional Nursing Home, Inc. v. Weinberger, supra, 490 F.2d at 844, citing Mourning v. Family Publications Service, 411 U.S. 356, 369 (1973) (Truth-in-Lending Act).

Appellants argue that § 1396a(a)(17)(B), when read with the legislative history, mandates a contribution-in-fact or "actually available" standard. Appellants contend that deeming on any basis for any length of time is impermissible. The state of Iowa argues that its current practice of deeming using a factual evaluation of income actually received and expenses necessarily incurred is authorized by the financial responsibility provision § 1396a(a)(17)(D). This is the basic holding of the district court, 443 F.Supp. at 1319-20, and Judge Ross herein: that the regulation has "nullified" the intent of Congress in § 1396a(a)(17)(D) to permit

a state to consider the financial responsibility of spouses. Slip op. at 12.

To answer appllants' argument that deeming is absolutely prohibited under the statute, I note that neither the statute nor the legislative history is so explicit. What the statute says is that states may consider only such income and resources as are "available" to the applicant and expressly delegates to the Secretary the power to prescribe the standards for determining what constitutes available income and resources. 42 U.S.C. § 1396a(a)(17)(B). The Secretary has interpreted "available" income and resources to include, in the case where one spouse has applied or is eligible for Medicaid in a couple separated by institutionalization of that spouse, only the income and resources of the ineligible spouse actually contributed to the institutionalized, eligible spouse after the month in which they cease to live together or are separated by institutionalization. 42 C.F.R. § 435.723(d). Thus, deeming is required in such a case for a certain period. In short, "available" is a statutory "term of art" which has been reasonably interpreted by the Secretary in the regulation at issue. Brief of the Department of HEW as amicus curiae at 17. See Batterton v. Francis, supra, 432 U.S. at 427-28 (administrative interpretation of statutory term "unemployment" in Title IV (AFDC) of the Social Security Act § 407(a), 42 U.S.C. § 607(a)).

The state of Iowa's argument that the deeming of income "without end" is permissible can be answered along similar lines. The Secretary has interpreted the statutory term "available" to require

deeming for only limited periods, up to a maximum of six months, depending upon whether one or both members of a couple are otherwise eligible for SSI and "cease to live together" or separated by institutionalization. 42 C.F.R. § 435.723(b), (c), (d).

As noted by the district court below, 443 F. Supp. at 1318-19, and Judge Ross herein, slip op. at 10-11, the voluminous legislative history of the Medicaid statute indicates that

> [t]hese provisions [§ 1396a(a)(17(A)-(D)] are designed so that the states will not assume the availability of income which may not, in fact, be available or over-evaluate income and resources which are available. Examples of income assumed include support orders from absent fathers which have not been paid or contributions from relatives which are not in reality received by the needy individual.

S. Rep. No. 404, 89th Cong., 1st Sess. 78, reprinted in [1965] U.S. CODE CONG. & AD. NEWS 1943, 2018 (hereinafter S. Rep. No. 404). The Secretary's interpretation of "available" in the regulation as "actually contributed" accurately implements the expressed Congressional intent that states make Medicaid eligibility decisions with "real rather than presumed dollars." Franssen v. Juras, 406 F. Supp. 1375, 1378 (D. Ore. 1975).

The specific reference in the legislative history to the consideration of "available" income and resources supports both the Secretary's primary role in defining "available" and the Secretary's

interpretation of "available" as contribution-in-fact or "actually contributed" in the regulation:

> Another provision [§ 1396a(a)(17)(B)] is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him [or her].

S. Rep. No. 404, supra (emphasis added). The deeming regulation treats the income and resources of an aged, blind or disabled individual under Medicaid in exactly the same manner as SSI, which is the title of the Social Security Act (Title XVI) "most appropriately applicable" to an aged, blind or disabled individual. Under SSI, the income and resources of spouses is deemed to be available to each other as long as they share the same household and, if the couple is separated, for up to six months depending upon the eligibility status of each spouse. See discussion below.

Of course, the more difficult question raised by the state of Iowa's argument is whether the "actually contributed" language in the regulation implementing § 1396a(a)(17)(B) has in effect "nullified" § 1396a(17)(D). See slip op. at 12;

Franssen v. Juras, supra, 406 F. Supp. at 1380 (Goodwin, J., dissenting). I agree with Judge Ross that § 1396a(a)(17)(D) specifically allows states to consider the financial responsibility of spouses (and parents). However,

> [i]t should be observed from the outset that § 1396a(a)(17)(D) does not require interspousal income attribution [deeming], nor does it stand for the proposition that the entirety of a spouse's income be automatically attributed to the other spouse in every instance. . . . Rather, the language in § 1396a(a)(17)(D), which refers to spouses, merely provides that the blanket prohibition which is imposed in that subsection upon such income attributions as are predicated on financial responsibility shall not act as a total barrier to all income attributions as between spouses.

Manfredi v. Maher, 435 F. Supp. 1106, 1109 n. 5 (D. Conn. 1977) (1972 option state) (emphasis in original); see also Gray Panthers v. Secretary of HEW, supra, 461 F. Supp. at 322; Herweg v. Ray, supra, 443 F. Supp. at 1319; Burns v. Vowell, 424 F. Supp. 1135, 1141 (S.D. Tex. 1976); Franssen v. Juras, supra, 406 F. Supp. at 1378. But see Norman v. St. Clair, supra, slip op. at 11-12.

In my opinion, § 1396a(a)(17)(D) authorizes states to enforce the financial responsibility of spouses (and parents) but not to authorize states to do so in a manner otherwise proscribed by the

statute. See Franssen v. Juras, supra, 406 F. Supp. at 1379. Under this statutory provision, the states are authorized to enforce their financial responsibility laws against spouses (and parents), where applicable, for medical expenses covered under Medicaid. If a state is one of the so-called "§ 209(b) states," as discussed further below, that state may enforce spousal financial responsibility either indirectly through its relative responsibility laws, if any, or directly through its Medicaid regulations. See Norman v. St. Clair, supra, slip op. at 11. However, if a state is an "SSI state," then the state may only enforce spousal financial responsibility through its Medicaid regulations to the extent permissible under the SSI statute. Any greater attempt to enforce spousal financial responsibility can only be effected through the state's relative responsibility laws, if any.

This construction of § 1396a(a)(17)(D) is not inconsistent with the legislative history. Referring to this statutory provision, the Senate Finance Committee report stated:

> The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care.

S. Rep. No. 414, supra (emphasis added). In my view, Congress did not intend to shield one spouse (or parents) from financial responsibility for the support of the other spouse (or minor children or adult blind or disabled children) simply because that spouse (or children) is covered by Medicaid. By comparison, Congress expressly precluded states from holding relatives other than spouses (or parents) financially responsible for medical expenses covered by Medicaid.

While "nothing in the statute or legislative history limits a state to enforcing this responsibility [of a spouse] only through the use of the state's relative responsibility law," slip op. at 12 (emphasis in original), a state cannot enforce its relative responsibility law in a manner which is otherwise inconsistent with federal statutes and regulations. E.g., Townsend v. Swank, 404 U.S. 282, 285 (1971); Rosado v. Wyman, 397 U.S. 397, 408 (1970) (AFDC). As will be discussed further below, in a SSI state, the extent and duration of deeming under Medicaid is limited by the statutory provisions and regulations of the Supplemental Security Income program, SSI, 42 U.S.C. § 1381 et seq. In my view, § 1396a(a)(17)(D) does not authorize states which link Medicaid eligibility directly to SSI eligibility (the "SSI-Medicaid link"), and are thereby required to use SSI eligibility requirements, to in effect impose an additional criterion for Medicaid eligibility. See Gray Panthers v. Secretary for HEW, supra, 461 F. Supp. at 321; Manfredi v. Maher, supra, 435 F. Supp. at 1112; Franssen v. Juras, supra, 406 F. Supp. at 1378.

Enforcement of Spousal Financial Responsibility

This analysis does not preclude the state from seeking some contribution from the noninstitutionalized spouse. Herweg v. Ray, supra, 443 F. Supp. at 1319-20. In fact, the prospect of a wealthy spouse abandoning an institutionalized spouse, thus evading his or her financial responsibility and "getting away with it" is something of a false issue. "Nothing in the [Social Security Act] precludes a state from exercising its financial responsibility laws . . . in cases of unwarranted neglect, where, for example, a wealthy individual refuses to support an institutionalized spouse, even though he or she would be financially able to do so." Manfredi v. Maher, supra, 435 F. Supp. at 1115 & n. 18. The following comment and response, published with the 1977 spousal financial responsibility regulations (42 C.F.R. § 448.3(b) (1977)), further supports the continued availability of state financial responsibility laws and actions brought thereunder to enforce spousal obligations to support, where appropriate:

> Comment: The proposed regulations are contrary to State laws specifying financial responsibility of relatives.
>
> Response: Federal law authorizes the establishment of Federal standards with respect to Medicaid eligibility determinations. However, the Medicaid statute [and regulations do] not preclude States from enacting laws of general applicability, specifying the responsibility of spouses and parents with respect to

retroactive recovery of the costs of medical assistance furnished by the State to eligible recipients.

42 Fed. Reg. 2686 (1977) (emphasis added).

Further, I note that the Medicaid statute, 42 U.S.C. § 1396a(a)(25), and regulations, 42 C.F.R. § 433.135, provide for determining and taking into consideration the legal liability of third parties to pay for Medicaid services. Although, in my opinion, this provision for third party liability was intended to encompass insurance liability rather than relative responsibility, I see no reason why relative responsibility, if applicable, could not be reached through this provision. For example, the state could bring a suit in state court under its relative responsibility law and obtain a support order. The support order could then be included among the economic resources of the Medicaid applicant or recipient in determining eligibility and state payment levels. However, the state may not withhold Medicaid benefits if the support payments will not be available to the Medicaid recipient within a reasonable time. 42 C.F.R. § 433.135(e)(2).

Medicaid Program - Historical Structure

At this point a brief history and description of the structure of the Medicaid program is necessary. Since the beginning of the Medicaid program in 1965, participating states were required to make all recipients of cash assistance eligible for Medicaid. A state was required to provide for "making medical assistance available to all

individuals receiving aid or assistance under any plan of the state approved under title I, X, XIV, or XVI, or part A of title IV, [the former categorical assistance programs; see discussion below] or with respect to whom supplemental security income benefits are being paid under title XVI [SSI] of this subchapter." 42 U.S.C. § 1396a(a)(10)(A). See generally 42 C.F.R. § 435.1. Before 1974, federally-assisted, state-administered welfare programs provided "cash assistance" to needy persons in four categories: (1) persons 65 or older (Title I, Old Age Assistance), (2) the blind (Title X, Aid to the Blind), (3) the disabled (Title XIV, Aid to the Premanently and Totally Disabled), and (4) certain types of families (Title IV-A, Aid to Families with Dependent Children or AFDC). At state option, cash assistance to the aged, blind and disabled could be made available under a consolidated program, Aid to the Aged, Blind and Disabled (former Title XVI).

Because an individual had to be both categorically related (that is, eligible as aged, blind, disabled or a member of a family with children deprived of the support of at least one parent) and financially eligible on the basis of income and resources, recipients of cash assistance under one of the four categorical assistance programs were termed the "categorically needy."

States could also elect to cover under Medicaid selected groups of individuals who were financially eligible for cash assistance but ineligible because of certain other requirements or who were financially eligible but did not wish to receive

cash assistance. For example, an individual may refuse SSI because it is welfare but accept Medicaid as medical assistance. Individuals covered under these optional coverage provisions were still considered "categorically needy" and were eligible for the same medical services provided under Medicaid to recipients of cash assistance.

States could limit Medicaid coverage to the "categorically needy" or could choose to extend Medicaid coverage to the aged, blind or disabled or members of families with dependent children who had too much income and/or resources to be eligible for cash assistance under the appropriate categorical assistance program but not enough for necessary medical care. Such individuals were termed the "medically needy." A state could use higher levels of income and resources to determine Medicaid eligibility than those used to determine eligibility for cash assistance. The state was required to deduct an applicant's incurred medical expenses from income in determining eligibility for Medicaid. Unlike eligibility for cash assistance, Medicaid eligibility under the "medically needy" coverage option did not depend solely upon the absolute amount of an individual's income. Thus, the "medically needy" are persons whose income is too low to meet their medical expenses but too high to qualify directly for cash assistance. E.g., Friedman v. Berger, supra, 547 F. 2d at 726. Because states would be covering more persons under the "medically needy" option, states were permitted to provide more limited medical services to the "medically needy" than those provided to the "categorically needy."

The "medically needy" Medicaid coverage option is not at issue in the present case. However, it should be noted that either an SSI state or a § 209(b) state may choose to cover the "medically needy" in addition to the mandatorily covered "categorically needy."

The 1972 Amendments

In 1972 the categorical assistance programs (except AFDC) were replaced by a new federal program (SSI) of caseh assistance for the aged, blind and disabled under a new Title XVI. Social Security Amendments of 1972, Act of Oct. 30, 1972, Publ L. No. 92-603, 86 Stat. 1381 (effective Jan. 1, 1974) (hereinafter the 1972 Amendments). The basic purpose of SSI was to assure a minimum level of income for persons who are aged, blind or disabled and without income and resources sufficient to maintain a standard of living at the established federal income level. 20 C.F.R. § 416.110. Federally administered and fully federally financed, SSI, effective January 1, 1974, replaced the previous, state-administered categorical assistance programs for the aged, blind and disabled in all jurisdictions except Puerto Rico, Guam and the Virgin Islands. 42 U.S.C. § 1381 et seq. (AFDC continued to be state-administered.) SSI established uniform, nationwide eligibility standards and financial requirements, expanded the definition of disability to include individuals under 18 and lessened the variations in levels of assistance from state to state.

Most individuals who had been receiving cash assistance under the previous, state-administered categorical assistance programs that had used more liberal eligibility requirements than SSI were considered to qualify for SSI for purposes of Medicaid coverage. In addition, states that had been making higher payments to individuals under the old categorical assistance programs were required to pay the difference between the higher benefit and the SSI benefit in the form of mandatory state supplements.

States could also pay optional state supplements. 42 U.S.C. § 1382e; 20 C.F.R. § 416.2001-.2090. When the SSI program, which is wholly federally financed, was implemented, the states were no longer required to pay part of the cash assistance benefits to the aged, blind or disabled (except for the mandatory state supplements). Congress encouraged the states to use the funds they had previously used to provide categorical assistance to the aged, blind or disabled to supplement SSI payments to the aged, blind or disabled in the form of "optional state supplements." See H.R. Rep. No. 92-231, 92d Cong., 2d Sess. (1971), reprinted in [1972] U.S. CODE CONG. & AD. NEWS 4989, 5185 (hereinafter H.R. Rep. No. 92-231). Congress later decided that the states could also provide Medicaid to individuals who receive optional state supplements. 42 C.F.R. § 435.230. By statutory definition, 42 U.S.C. § 1382e(a), optional state supplements are paid to individuals who receive SSI benefits or who would be eligible except for the level of their income to receive SSI benefits. Thus, the eligibility standards

for an optional state supplement are identical to SSI except for income. In practice, the optional state supplement program is more inclusive than SSI.

Because SSI financial eligibility requirements are more liberal than the financial eligibility requirements of many of the old categorical assistance programs, many more individuals now qualify for cash assistance.

> When Congress initially created SSI, it intended to require that all states provide Medicaid assistance automatically to all SSI recipients. Because this would have automatically resulted in a huge increase in the Medicaid rolls in the various states, and Congress feared that some states might opt out of the Medicaid program altogether, Congress added a provision which gave states the option of utilizing more restrictive [Medicaid] eligibility conditions. Under this provision, section 1902(f) of the [Social Security] Act, 42 U.S.C. § 1396a(f) [§ 209(b) of the 1972 Amendments], a state was permitted to use any financial eligibility condition [for Medicaid] which was no more restrictive than that in use under the state's January 1972 eligibility conditions for its categorical [assistance] programs.

Gray Panthers v. Secretary of HEW, supra, 461 F. Supp. at 321. Section 209(b) of the 1972 Amendments thus changed the basic Medicaid

coverage requirement: the states are no longer required to provide Medicaid to all cash assistance (SSI) recipients; under § 1396a(f) the states can choose to provide Medicaid to a more restricted group of cash assistance recipients defined by the state's 1972 categorical assistance eligibility requirements. See West v. Cole, 390 F. Supp. 91 (N.D. Miss. 1975).

In a § 209(b) state Medicaid eligibility is not dependent upon receipt of or eligibility for cash assistance (SSI benefits), but instead is determined with reference to a historical standard (which can be no more restrictive than the 1972 categorical assistance requirements). For example, in a § 209(b) state, a particular individual could receive SSI but not be eligible for Medicaid. (Such an individual could be eligible for Medicaid under a "spend-down" provision. 42 U.S.C. § 1396a(f); e.g., Friedman v. Berger, supra, 547 F.2d 724; see also H.R. Rep. No. 92-231, supra, at 5061.) In contrast, in an SSI state, an individual who receives SSI is automatically eligible for Medicaid. The same automatic Medicaid eligibility also follows if the individual is eligible for (but does not actually receive) SSI and the state has elected to provide Medicaid under one of the "optional categorically needy" programs, for example, for the institutionalized, in an SSI state. This is the SSI-Medicaid link discussed below.

Present Structure

Under the present structure of Medicaid, the states must provide Medicaid coverage to the "categorically needy" under one of two major options:

(1) to all SSI recipients or (2) to those cash assistance recipients who meet eligibility requirements more restrictive than those under SSI, but which are no more restrictive than the eligibility requirements in effect in January 1972 for the state's previous categorical assistance programs. 42 U.S.C. § 1396a(a)(10)(A), (f); 42 C.F.R. § 435.120,.121. Thirty-four states, including Iowa, and the District of Columbia have chosen to provide Medicaid coverage under the SSI option. These states are usually referred to as "SSI states." Fifteen states have chosen the other major option; these states may be referred to as "§ 1902(f) states" after the applicable section of the Social Security Act or "§ 209(b) states" after the applicable section of the 1972 Amendments or as "1972 option states" after the year designated as the historical standard. I will use the designation "§ 209(b) state."

States must also provide Medicaid coverage to AFDC recipients, recipients of mandatory state supplements, and to certain other groups of individuals who were eligible for Medicaid in 1973 under optional coverage provisions, such as "essential spouses" or individuals who were institutionalized in December 1973. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 435.1(d)(4), .110(a), .130-.133. However, this mandatory Medicaid coverage is not at issue in the present case.

States may, as a matter of state option, choose to provide Medicaid coverage to certain other groups of individuals, the so-called "optional categorically needy." 42 U.S.C. § 1396a(a)(10)(C)(III); 42 C.F.R. § 435.200-.231. In general, these

individuals meet the eligibility requirements for cash assistance programs but do not actually receive cash payments or would be eligible for cash payments if they were not in medical institutions. This is the "gap" discussed by Judge Ross. Slip op. at 15. Because Medicaid coverage depends on receipt of cash assitance, 42 U.S.C. § 1396a (a)(10)(A), the classification "optional categorically needy" allows the states to selectively extend Medicaid coverage to individuals who are otherwise eligible to receive cash assistance but not actual recipients.

The "optional categorically needy" classification is also important because the Medicaid statute requires the states to provide Medicaid coverage to the "medically needy" if they choose to provide Medicaid coverage to individuals other than the "categorically needy." 42 U.S.C. § 1396a(a)(10)(C). (As discussed above, the "medically needy" are aged, blind or disabled individuals or certain families and children whose income and resources are too high to qualify as "categorically needy" but insufficient to meet their medical expenses.) The states may choose to extend Medicaid coverage to the "medically needy," but choosing to do so substantially increases the number of Medicaid eligibles and the cost. However, because the "optional categorically needy" are considered among the "categorically needy," the "optional categorically needy" classification enables states to evade this restriction and selectively extend Medicaid coverage to certain groups (such as the institutionalized) which they feel are the most in need of state help without having to provide Medicaid to the "medically needy." 42 U.S.C. § 1396a(a)(10)(C)(III).

The state of Iowa provides Medicaid to the "categorically needy" under the SSI option and to several groups of the "optional categorically needy," including the institutionalized under 42 C.F.R. § 435.211, .231, and recipients of optional state supplements under 42 C.F.R. § 435.230. Iowa does not provide Medicaid coverage to the "medically needy."

The SSI - Medicaid Link

As discussed above, in SSI states, SSI eligibility requirements are in effect Medicaid eligibility requirements because all SSI recipients are automatically eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A). This is the SSI - Medicaid link: Medicaid eligibility is predicated upon SSI eligibility.

To be eligible for SSI, and individual must be categorically related (aged, blind or disabled) and financially eligible. The income and resources requirements an SSI applicant must satisfy depend in part on whether the applicant has a spouse, whether the applicant and such spouse (if any) are living in the same household and whether such spouse is an "eligible spouse." Congress evidently made these distinctions in order "to take account of the fact that two people living together can live more economically than they would if each lived alone." H.R. Rep. No. 92-231, supra, at 5136. Accordingly, Congress set the maximum SSI benefit payable to a married couple composed of two eligible individuals (an "eligible couple") (currently $312.30/month) lower than the combined maximum SSI benefit payable to two eligible individuals

(currently $208.20 x 2 = $416.40/month). (Comparable "single household" restrictions apply to children and parents.) The SSI definitions of "eligible individual" and "eligible spouse" and the treatment of separation and institutionalization under SSI, as discussed below, were drafted to take advantage of the economy of scale of a common household. See Franssen v. Juras, supra, 406 F. Supp. at 1378.

For the purposes of determining eligibility and the amount of benefits, the SSI statute expressly requires the deeming of income and resources from one spouse to the other spouse as long as they live together in the same household. 42 U.S.C. §§ 1382(a)(2), (b)(2); 1382c(f)(1). Deeming is mandated by the statutory definition of "eligible individual" when both spouses are aged, blind or disabled, 42 U.S.C. § 1382(a)(2), and by express statutory provision when only one spouse is aged, blind or disabled, 42 U.S.C. §1382c(f)(1).

Only "eligible individuals" are entitled to SSI benefits. 42 U.S.C. § 1381a. The statutory definition of "eligible individual" provides that

> (1) Each aged, blind or disabled individual who does not have an eligible spouse and --
>
> > (A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title)

for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of the title, are not more than (i) in case such individual has a spouse with whom he is living, $2,250, or (ii) in case such individual has no spouse with whom he is living, $1,500,

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and--

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calend calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than $2,250,

shall be an eligible individual for purposes of this subchapter.

42 U.S.C. § 1382(a)(1), (2) (emphasis added). (Section 1382f provides for cost-of-living increases. The current maximum income level is $2498.40 for an individual who does not have an eligible spouse under § 1382(a)(1)(A) and $3,747.60 for an individual who soes have an eligible spouse under § 1382(a)(2)(A).) An "eligible spouse" is defined by the SSI statute as "an aged, blind or disabled individual who is the husband or wife of another aged, blind, or disabled individual and who has not been living apart from such other aged, blind, or disabled individual for more than six months." 42 U.S.C. § 1382c(b) (emphasis added).

Thus, in the case of a married couple composed of an "eligible individual" and an "eligible spouse" (that is, where both spouses are aged, blind or disabled), the applicant's income and resources are considered together with those of the eligible spouse in determining eligibility (for SSI). Deeming is required as well in determining the level of benefits:

> (2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

42 U.S.C. § 1382(b)(2) (emphasis added). (The maximum SSI benefit payable to such an eligible couple is currently $3,747.60.) The income and

resources of each spouse are deemed to be available to the other. This deeming will continue as long as they live together in the same household or until they have been living apart for six months. E.g., Mansfield v. Weinberger, 398 F. Supp. 965, 968-69 (D.D.C. 1975). (Because of the definition of "eligible spouse," a spouse is no longer an "eligible spouse" after a separation of six months.) In other words, if both spouses are aged, blind or disabled, the income and resources of one are deemed to be available to the other as long as they in fact share the same household or until they have been separated for six months.

In the case of a married couple composed of an eligible individual and an ineligible spouse, Congress recognized that such a couple theoretically enjoys a similar economy of scale as long as they maintain one household and expressly provided that

> [f]or purposes of determining eligibility for and the amount of benefits for any individual who is married and whose spouse is living with him in the same household but is not an eligible spouse, such individual's income and resources shall be deemed to include any income and resources of such spouse, whether or not available to such individual, except to the extent determined by the Secretary to be inequitable under the circumstances.

42 U.S.C. § 1382c(f)(1) (emphasis added). In other words, Congress required that where an eligible individual lives in the same household with

his or her ineligible spouse, then such eligible individual's income and resources shall include the income and resources of the ineligible spouse. (The actual computation of "deeming" is quite complex. See 20 C.F.R. § 416.1185 (deeming of income), .1202 (deeming of resources).) Deeming in the case of an eligible individual and ineligible spouse will continue as long as they live together in the same household. Thus, deeming stops in theory at the time such spouses no longer live together. However, any chang in living arrangements (such as separation) will not be recognized by the SSI administrative process until the beginning of the month after the month in which the change in living arrangements occurred. (Evidently changes in eligibility status are administratively cognizable only at monthly intervals. Although redetermination of eligibility and amount of benefits is required at least once every twelve months, 20 C.F.R. § 416.222, a basic change in eligibility status without loss of eligibility will be reflected in a redetermination of payment amount for each month within a quarter. 20 C.F.R. § 416.222.)

Couples may be separated by the institutionalization of one or both spouses. In the event one spouse (or both) is institutionalized, such spouses obviously no longer "live together in the same household." In making SSI eligibility determinations for spouses who are separated by institutionalization, the income and resources of one spouse are deemed to be available to the other spouse until the spouses have been separated for six months in the case of an eligible individual and eligible spouse or until the month after the month during which one spouse was institutionalized in the case of an eligible

individual and ineligible spouse.

In addition, the amount of SSI benefits changes when one spouse has been institutionalized for one month. 42 U.S.C. § 1382(e)(1)(B) provides:

> (B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX of this chapter, the benefit under this subchapter for such individual for such month shall be payable--
>
> (i) at a rate not in excess of $300 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;
>
> (ii) in the case of an individual who has an eligible spouse, if only one of them is in such a hospital, home of facility throughout such month, at a rate not in excess of the sum of--
>
> (I) the rate of $300 per year (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the one who is in such hospital, home, or facility), and

(II) the applicable rate specified in subsection (b)(1) [maximum individual benefit] (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other) . . . .

Basically, the institutionalized spouse receives a much lower SSI benefit (maximum $25/month) and the noninstitutionalized spouse, if eligible, receives an SSI benefit at the rate applicable to an eligible individual (instead of half the rate applicable to an eligible couple). 42 U.S.C. § 1382(e)(1)(B)(i) (eligible individual who does not have an eligible spouse), (ii) (eligible individual who has an eligible spouse); 20 C.F.R. § 416.231.

In sum, under the SSI program, deeming is mandated by statute as long as the couple lives together in the same household. If the couple ceases to live together, deeming will cease at the beginning of the month after the month in which they cease to live together if only one spouse is aged, blind or disabled and after six months of separation if both spouses are aged, blind or disabled. (This difference in the duration of deeming is the result of the statutory definition of "eligible spouse" which sets a six month separation in part to discourage couples from living apart to collect more benefits.)

These periods of deeming should be familiar to the reader; they are precisely the periods of deeming specified in the Medicaid regulation at issue, 42 C.F.R. § 435.723. This congruence is not coincidental; it is compelled by the relationship

between the SSI and the Medicaid programs. This is because the Medicaid regulation at issue establishes spousal financial responsibility criteria that apply, in an SSI state, when determining the Medicaid eligibility of certain groups of individuals who, though not in fact eligible to receive SSI benefits, are identified by referring to SSI eligibility. For example, 42 C.F.R. § 435.723 applies to institutionalized individuals who would be eligible to receive SSI benefits if they were not institutionalized (42 C.F.R. § 435.211) and institutionalized individuals who, because of the level of their income, would not be eligible to receive SSI benefits even if they were not institutionalized, but whose income is below a specified level (42 C.F.R. § 435.231). The Medicaid eligibility of these institutionalized individuals depends upon their SSI eligibility, except for the level of their income.

Why is there a special exception for Medicaid eligibility for the institutionalized? As noted by Judge Ross, slip op. at 15-16, there is a "gap" in the Medicaid coverage of the institutionalized. This "gap" is the product of the interaction between two statutory provisions: 42 C.F.R. § 1396a(a)(10)(A), the part of the Medicaid statute which links Medicaid eligibility to the receipt of cash assistance, and 42 U.S.C. § 1382(a)(1)(B), the SSI statutory provision which sets the maximum SSI benefit payable to an institutionalized individual (technically, to an individual who is in a hospital, extended care facility, nursing home or intermediate care facility receiving Medicaid payments with respect to that individual's care) at the rate of $300/year ($25/month). See 20 C.F.R. § 416.231.

The SSI benefit level for the institutionalized was set at a maximum of $25/month because Congress anticipated that "most subsistence needs [of the institutionalized] are met by the institution [and paid for by Medicaid] and full benefits are not needed. Some payment to these people, though, would be needed to enable them to purchase small comfort items not supplied by the institution." H. R. Rep. No. 92-231, supra, at 5136. The $25/month maximum, which is reduced by nonexcluded income, sets a very restrictive income standard to determine eligibility for SSI benefits for the institutionalized. In practice, an institutionalized individual can receive up to $45/month in nonexcluded income before becoming ineligible for an SSI benefit. (There is a $20/month income disregard allowed under 42 U. S. C. § 1382a(b)(2)(A).)

For example, a majority of the institutionalized (that is, the elderly in nursing homes) receive some income, typically in the form of Title II Social Security benefits (Old Age, Survivors and Disability Insurance under § 201 of the Act, 42 U. S. C. § 401 et seq.). Because Title II benefits are nonexcluded income, see 42 U. S. C. § 1382a(a)(2)(B), (b), receipt of such benefits reduces the amount of the SSI benefit. If an institutionalized individual receives $30/month in Title II benefits, the amount of such individual's SSI benefit is $15/month ($25/month maximum SSI benefit reduced by $10, which is the $30/month Title II benefit less the $20/month income disregard). However, a Title II benefit of $45/month (or more) would reduce the SSI benefit to $0 ($25/month maximum SSI benefit reduced by $25, which is the $45/month Title II benefit less the $20/month income disregard).

What this means is that any insitutionalized individual who receives $45/month or more of nonexcluded income, which is a very small amount, is not eligible for SSI (technically, such an individual is not eligible to receive an SSI benefit) and thus loses his/her Medicaid eligibility. That individual has lost the SSI "link" to Medicaid eligibility.

Congress recognized the severe hardship this "gap" in Medicaid coverage imposed upon the institutionalized and amended the Medicaid statute in 1973. Act of Dec. 31, 1973 (Social Security Amendments of 1973), Publ L. No. 93-233, § 13(a)(3), 87 Stat. 960 (codified in 42 U.S.C. § 1396a(a)(10)(C)(III); 42 C.F.R. § 435.211,.231; see also 119 Cong. Rec. 43227 (remarks of Rep. Ullman). States may close the "gap" by extending Medicaid eligibility to institutionalized individuals who are ineligible for SSI (or AFDC or an optional state supplement under 42 C.F.R. § 435.230) because of the lower income standards used under those programs to determine eligibility for institutionalized individuals, but who would be eligible for SSI (or AFDC or an optional state supplement) if they were not institutionalized. 42 C.F.R. § 435.211. In addition, states may also extend Medicaid eligibility to institutionalized individual who are aged, blind or disabled and who, because of the level of their income, would not be eligible for SSI (or an optional state supplement) even if they were not institutionalized (income above $208.20/month for eligible individual who does not have an eligible spouse; income above $312.30 for eligible individual who has an eligible spouse), but whose income is below a certain level. 42 C.F.R. § 435.231,.1005 (maximum income standard

under § 435.231 is 300% of the maximum SSI individual benefit of $208.20/month or $624.60; the maximum income standard set by the state of Iowa under this section is currently $600/month, effective July 1, 1979).

The higher income standard permissible under § 435.231 presumably is a reflection of the extraordinary costs of institutional care. See 42 C.F.R. § 435, 722(a). Theoretically, the use of a higher income level for institutionalized individuals is based upon a fictitious optional state supplement where no benefits are actually paid or received by the institutionalized individual. See 42 U.S.C. § 1382e(e) (reduction of SSI benefit by amount of optional state supplement in case of institutionalized individual); H.R. Rep. No. 92-203, supra, at 5186 (optional state supplements based upon special needs).

In sum, Medicaid eligibility in an SSI state is premised upon SSI eligibility. Medicaid eligibles (except for AFDC recipients or individuals otyerwise eligible for AFDC or the medically needy) in an SSI state are either (1) SSI recipients; (2) optional state supplement recipients, who by definition are either SSI recipients or would be eligible for SSI except for the level of their income; (3) individuals who are eligible for SSI or an optional state supplement but who do not actually receive such benefits; (4) institutionalized individuals who would be eligible for SSI or an optional state supplement except for their institutional status; or (5) institutionalized individuals who would not be eligible for SSI or an optional state supplement because of the level of their income, even if they were not institutionalized, but whose income is

nonetheless below a certain level. The financial eligibility requirements of SSI or the optional state supplement program apply to those who are actually receiving those benefits; the Medicaid regulations at issue (42 C.F.R. § 435.700-.740) apply only to individuals who are not receiving actual benefits. 42 C.F.R. § 435.700.

Post-eligibility Treatment: Allocation of Income of Institutionalized Individuals Toward Cost-of-Care

It should be noted that 42 C.F.R. § 435.725 requires that the income of an institutionalized spouse in excess of a personal needs allowance ($25/month) (42 C.F.R. § 435.725(c)(1)) and a maintenance allowance for the support of the non-institutionalized spouse (42 C.F.R. § 435.725(c)(2)) or the family (42 C.F.R. § 435.725(c)(3)) be allocated toward the cost-of-care of the institutionalized spouse. In those cases where the institutionalized spouse is the source of most of the couple's or family's income, the allocation of patient income toward cost-of-care does impose significant hardships upon the noninstitutionalized spouse or family, who are thus constrained to live on a "maintenance allowance." The maintenance allowances are generally based on the income standards used to determine Medicaid eligibility and correspond to welfare subsistence levels. E.g., 42 C.F.R. § 435.725(c)(3)(iii) (maximum family maintenance allowance is state AFDC level or medically needy income standard). To this extent, appellants and Judge Ross, slip op. at 19, are accurate in observing that the "price" of Medicaid coverage for the institutionalized spouse is a rather frugal existence for the other spouse or family.

The allocation of income twoard cost-of-care equalizes the financial condition of the spouses and/or families of institutionalized Medicaid recipients. For example, because of the optional Medicaid coverage provisions, in particular 42 C.F.R. § 435.231, an institutionalized individual may be eligible for Medicaid even though his or her income greatly exceeds the maximum SSI financial eligibility level. In the absence of the allocation of income toward cost-of-care required by 42 C.F.R. § 435.725(c), the spouse or family of such an institutionalized individual who qualified for Medicaid under the higher income option would be much better off than the spouse or family of an institutionalized individual who qualified under the SSI income option (42 C.F.R. § 435.211). The "price" of Medicaid coverage for the institutionalized individual under the higher income option is that his or her spouse or family exists upon the income of the SSI spouse or family. In effect, the spouse or family pays for many thousands of dollars' worth of institutional care with the balance of the institutionalized individual's income above the spouse or family maintenance allowance.

Consider the following examples. I have drastically simplified the calculations. Further assume $200/month is the maximum individual SSI benefit and that the state has a higher income option standard for institutionalized individuals of $600/month under 42 C.F.R. § 435.231.

(1) A and B are married. No children.
A is disabled and institutionalized.
B is not aged, blind or disabled.
A has $600/month income.

B has no income

A just meets the higher income option standard.
A's allocation of income toward cost-of-care is $375. ($600 less $25 personal needs allowance less $200 maximum spouse allowance)

(2) Same facts except A has income of $400/month.

A meets the higher income option standard.
A's allocation toward cost-of-care is $175. ($400 less $25 personal needs allowance less $200 maximum spouse allowance)

(3) Same facts except A has income of $200/month.

A meets the SSI income option standard under 42 C.F.R. § 435.211.
A's allocation toward cost-of-care is 0. ($200 less $25 allowance less $200 maximum spouse allowance; B receives the $175 balance)

Thus, the allocation toward cost-of-care increases as the institutionalized individual's income exceeds the SSI income option level.

Moreover, Mr. Herweg's ineligibility for Medicaid, the "devastating result" described on page 19 of the slip opinion, is simply the consequence of an individual having too much income to qualify for Medicaid, even under the higher income option for the institutionalized. Mr. Herweg's gross monthly income ($1,350) exceeds the federal income maximum of $624.60 per month (300% of the maximum SSI individual benefit of $208.20). He is therefore ineligible for Medicaid under the higher income option for institutionalized individuals (42 C.F.R. § 435.231) and the optional state supplement (42 C.F.R. § 435.230) because of the level of his income. (Further, Mr. Herweg's net monthly income exceeds Iowa's maximum of $600 per month. After deduction of the $20 income exclusion and the earned income exclusion of $65 plus half the remaining amount, Mr. Herweg's net monthly income is $632.50) Such a result is really an argument in favor of the state electing to provide Medicaid to the medically needy, who by definition have medical expenses which exceed their income, or Congressional amendment of Title XIX to provide Medicaid to individuals, regardless of income, who suffer catastrophic illness and/or require institutional care. Quite frankly, the cost of institutional care is probably beyond the economic resources of all but the wealthiest individuals.

Medicaid Eligibility Determination of Elvina Herweg

Elvina Herweg is permanently and totally disabled and requires institutional care. It appears from the record that she has no independent income, such as a pension or Social Security benefits. Darrell Herweg is not aged, blind or disabled.

Elvina Herweg was institutionalized on November 1, 1976. Darrell Herweg applied for Medicaid on her behalf on January 20, 1977, long after the month in which they ceased to live together (November 1976). As of January 20, 1977, Elvina was eligible for the maximum $25/month SSI benefit for institutionalized individuals and, as an SSI recipient, eligible for Medicaid. As of December 1, 1976, the month after the month they ceased to live together, the state could not deem the income or resources of Darrell Herweg to be available to his wife.

However, if Darrell Herweg had submitted the Medicaid application on November 1, 1976, Elvina's income and resources for the purposes of determining Medicaid eligibility would have included Darrell Herweg's income and resources to the extent specified in the SSI deeming regulation, 20 C.F.R. § 416.1185, and Medicaid deeming regulation for SSI states, 42 C.F.R. § 435.723. The state would have made one Medicaid eligibility and allocation toward cost-of-care determination as of November 1, 1976, and a second as of December 1, 1976 (change in living arrangements).

I believe the SSI (and thus Medicaid) calculations for the first month (November 1976) would have been:

Darrell Herweg - gross income per month	$1,350.00
(SSI income defined in 20 C.F.R. § 416.1102(a); earned income refers to gross amount of wages under 20 C.F.R. § 404.429(c))	
Reduced by an allocation for each child under 21 and neither blind nor disabled - 3 children	-312.30
(amount of allocation is difference between SSI benefit rate for an individual and that for a couple; $312.30-$208.20 = $104.10) (20 C.F.R. § 416.1185(a)(1))	
	$1,037.70

Because this acount exceeds one-half of the SSI benefit rate for an eligible individual ($208.20 x 1/2 = $104.10), all of this amount is deemed to be available to Elvina Herweg. 20 C.F.R. § § 416.1185(a)(2), (3).

This amount is further reduced by appropriate income exclusions to determine "countable income." 20 C.F.R. § 416.1185(a)(3)(ii). "Countable income" is the amount of income used to determine an applicant's eligibility for SSI and, if eligible, the amount of benefits. 20 C.F.R. § 416.1115(a).

Balance	$1,037.70
Reduced by $20 income exclusion (20 C.F.R. § 416.1145(b)(9), .1165)	-20.00
Reduced by earned income exclusion ($65 plus half remaining amount; 20 C.F.R. § 416.1145(b)(10), .1167)	-541.35
	$476.35

Because this amount exceeds the SSI benefit payable to an eligible couple ($312.30), Elvina Herweg would not be eligible for SSI or Medicaid as of November 1, 1976, if the state only provided Medicaid to SSI recipients. 20 C.F.R. § 416.1185(a)(3)(iii).

However, Iowa has elected to use a higher income standard in the case of institutionalized individuals. 42 C.F.R. § 435.231. (The regulations technically require the higher income standard be applied effective with "the first full month of institutionalization," 42 C.F.R. § 435.722(c). Administratively, however, states are considered to be in compliance with the regulations if Medicaid eligibility is determined as of the day of institutionalization.) Under the higher income standard, a Medicaid applicant must in effect meet two income tests: (1) the applicant's gross monthly income must be below the federal income maximum of $624.60/month (300% of the maximum SSI individual benefit, $208.20) (42 C.F.R. § 435.1005), and (2) the applicant's net income (gross monthly

income less applicable SSI disregards) is less than Iowa's higher income standard of $600/month. 42 C.F.R. § 435.722(a), (b).

Because Elvina Herweg has no other income, her gross monthly income consists of the amount of income deemed to be available to her from her husband, $476.35, which is within the federal income maximum ($624.60). Deemed income is considered unearned income and is reduced by the $20 per month income exclusion (20 C.F.R. § 416.1165). Elvina's net income of $456.35 per month is less than Iowa's higher income standard of $600 per month. She would thus be eligible for Medicaid as of November 1, 1976.

Further, under 42 C.F.R. § 435.725, Elvina's allocation toward cost-of-care (client liability) would be $476.35 (total income) less $25.00 (minimum amount protected for an institutionalized individual), or $451.35. No additional allowances for maintenance of her husband or children would be made because maintenance allowances were already included in the deeming calculations under 20 C.F.R. § 435.1185.

Because deeming would have ceased as of December 1, 1976, Elvina's eligibility for SSI would have been redetermined as an individual as of December 1, 1976. She also would have been institutionalized for one month by that date. Because she has no other income, she would have easily qualified under the lower income standards for institutionalized individuals, $25/month reduced by nonexcluded income. (Even assuming she had some independent income, as long as her

gross monthly income was less than $624.60 and her net monthly income was less than $600, she would have been eligible for Medicaid in Iowa under the higher income option for institutionalized individuals.) Because Elvina has no income as of December 1, 1976 (deeming ceases), she has no income from which any allocation toward cost-of-care can be made. Her allocation toward cost-of-care is thus $0.

Income Exclusions

As noted by Judge Ross, slip op. at 17-18, I agree that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities should be included as unearned income in determining SSI and Medicaid eligibility and amount of benefits. See 42 U.S.C. § 1382a(a)(2)(B); 20 C.F.R. § 416.1101(a) (income in general)., 1130 (types of periodic payments included in unearned income), .1146 (exclusions from income provided by other federal statutes), .1236 (exclusions from resources provided by other federal statutes).

Conclusion

I would hold that the state of Iowa as an SSI state cannot deem the income and resources of one spouse to be available to the other in making Medicaid eligibility determinations other than to the extent and for the duration specified in the applicable regulations, 42 C.F.R. § 435.700.725.

Chief Judge Lay, Judge Heaney, and Judge Stephenson concur in the result reached in Judge McMillian's opinion.

A true copy.

ATTEST:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

FILED
JAN 19 1978

Clerk, U. S. District Court
Southern District of Iowa

ELVINA M. HERWEG, et al.,	)	
	)	CIVIL NO.
Plaintiffs,	)	77-222-1
	)	
vs.	)	MEMORANDUM
	)	OPINION AND
ROBERT D. RAY, et al.,	)	ORDER
	)	
Defendants.	)	

This is an action under 42 U. S. C. § 1983 seeking declaratory and injunctive relief pursuant to 28 U. S. C. §§ 2201 and 2202. Plaintiffs also seek class action certification pursuant to Federal Rules of Civil Procedure 23(a) and 23(b)(2). In substance plaintiffs ask this Court to declare Iowa Department of Social Services Manual Letter No. XII-1-28 pt. 2 dated June 3, 1977 invalid and to enjoin its enforcement. Such policy letter was authorized by House File 464, section 18, Acts of the 67th General Assembly of the State of Iowa. This letter contains a formula by which a portion of the income of a non-institutionalized spouse is "deemed" available to meet the needs of an

institutionalized spouse who receives Medicaid payments under Title 42 U.S.C. § 1396 et seq. Jurisdiction of the Court is proper under 28 U.S.C. § 1331 and 42 U.S.C. § 1343(3) and (4).

The State of Iowa has adopted and filed with the Department of Health, Education and Welfare (HEW) a plan for the implementation of Title XIX Medical Assistance programs, Iowa having chosen to participate in the Medicaid program. This state plan allegedly failed to comply with the statute and HEW regulations as set forth in 45 C.F.R. § 248.3(b). Defendant Burns, however, has indicated an intention to continue the procedure currently in effect.

Plaintiff Elvina Herweg is an adult resident of the State of Iowa who is permanently and totally disabled. The action is being pursued by her husband and next friend Darrell Herweg. She was born December 21, 1930 and is now 47 years of age. In August of 1976 she suffered aneurisms and cerebral hemmorrhaging on both the left and right sides and has since remained in a comatose state. Darrell Herweg applied for and received medical assistance for her hospital care on October 7, 1976. On January 20, 1977, he applied for Medicaid assistance for an extended care facility. Elvina Herweg had been placed in a skilled long-term facility on November 1, 1976.

At the time of filing this action Darrell Herweg was employed as a butcher for the Hinky Dinky supermarkets in Council Bluffs, Iowa, with a gross income of $1,350 per month ($1,032 net). He currently has three teenage daughters living

at home. Based on the original Department of Social Services (Department) calculations, he was required to contribute $234.80 per month towards his wife's care which total approximately $1,374 per month excluding fees of physicians and costs of medicine.

On June 2, 1977 the Department issued a Notice of Decision cancelling medical assistance for Elvina Herweg effective June 30, 1977 because under revised formula calculations well over one half of Darrell Herweg's income was "deemed" available for his wife's care, causing her "income" to be higher than the cut-off level. On June 7, 1977 Darrell Herweg appealed the decision to cancel assistance. The appeal hearing was held July 15 and on July 21, 1977 the original decision was affirmed. Subsequent to this Court's grant of a Temporary Restraining Order on July 28, 1977 the Department on August 11, 1977 issued a new "Proposed Decision" which modified the formula calculations for determining what portion of Darrell Herweg's income should be "deemed" available for Elvina Herweg's support as follows:

$ 1,350.00	gross monthly income
- 65.00	work expenses
1,285.00	÷ 2 equals 642.50
$ 642.50	
- 177.80	living allowance for non-institutionalized spouse
$ 464.70	
- 269.40	living allowance for three dependents computed at 89.80 for each of the three dependents

$	195.30	deemed to be Elvina Herweg's income from Darrell Herweg
-	20.00	disregard of income (Elvina Herweg's income)
$	175.30	
-	25.00	personal needs for spouse in
$	150.30	institution

Under this formula Darrell Herweg is required to provide $150.30 per month toward the total expenses of his wife's institutionalization. If he does not, eviction would be imminent.

Plaintiff's specific contentions are as follows:

1. The "deeming" practices ultilized by defendants pursuant to House File 464, section 18 violate the applicable implementing regulations, 45 C.F.R. § 248.3(b) which require that no deeming or attribution of income occur subsequent to the end of the first calendar month after one spouse enters the institution.

2. The deeming procedures violate the Medicaid statute, 42 U.S.C. § 1396a(a)(17) which requires that: (a) a state have reasonable standards for determining Medicaid assistance; (b) that such plan must provide that only income and resources actually available to the Medicaid recipient be considered; (c) that income and resources be reasonably evaluated; and (d) that the State take into account for purposes of determining appropriate payment from the non-institutionalized spouse, income only of those relatives legally responsible for her support.

3. The practice and concept of "deeming" create an irrebuttable presumption that the non-institutionalized spouse is capable of paying the amount computed by the formula set forth in the manual and that such amount is actually available. Such irrebuttable presumptions are not rationally related to a legitimate state interest and are accordingly violative of the Due Process Clause of the Fifth Amendment to the United States Constitution.

4. The imposition of an additional eligibility requirement on otherwise qualified Medicaid recipients (the payment of a "deemed" available amount) creates two classes of Medicaid recipients. One class consists of unmarried institutionalized Medicaid recipients, the other, married institutionalized Medicaid recipients. Disparate treatment between such classes is irrational and capricious thus violating the Equal Protection Clause of the Fourteenth Amendment.

Medicaid is a federally sponsored welfare program designed to provide medical benefits to those with limited incomes and resources. The overall purpose is to provide a "coordinated approach for health insurance and medical care for the aged under the Social Security Act". See 1 U.S. Code Cong. & Ad. News 1943 (89th Cong. 1st Sess. 1965). See generally 42 U.S.C. §§ 1396 et seq. In order to qualify for medical assistance, individuals must be within eligibility limits for approved categorical assistance programs such as Title XVI (Supplemental Security Income), Title IV-A (Aid for Families with Dependent Children) or a state supplemental payment

plan, either before or after medical expenses are taken into account. 42 U.S.C. §§ 1396(a)(10), 1396a(f); 45 C.F.R. § 248; Manfredi v. Maher, 435 F. Supp. 1106, 1108 (D. Conn. 1977).

Federal law places certain limitations upon the eligibility criteria which States may impose under Medicaid plans. See Manfredi v. Maher, supra; Burns v. Vowell, 424 F. Supp. 1135, 1138 (S.D. Tex. 1976) (limited to preliminary injunction consideration only); Franssen v. Juras, 406 F. Supp. 1375 (D. Ore. 1975).

The precise issue is whether the State's method of computing the income available under the circumstances is in conflict with the statute and departmental regulations. Plaintiffs claim that

> [t]his bureaucratic determination that income is available fails to consider the real contours of the situation; by imputing income to the institutionalized spouse (or, actually, to the institution which provides the care), the state ignores the fixed costs of the non-institutionalized spouse, thus forcing an impossible choice. If the non-institutionalized spouse does not make all of the payments in an effort to maintain his or her own standard, then that spouse runs the serious risk that the nursing home, which is necessarily only receiving a portion of the cost of care, will evict the institutionalized spouse.

THE STATUTE

Title 42 U.S.C. § 1396a(a)(17) provides in its pertinent parts:

> (a) A State plan for medical assistance must--
>
> . . . .
>
> (17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, . . .) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient . . . . (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 . . . . (Emphasis supplied)

The voluminous legislative history indicates that the provisions of 42 U.S.C. § 1396(a)(17) were "designed so that the States will not assume the availability of income which may not, in fact, be available". (Emphasis supplied) S. Rep. 404,

1 U.S. Code Cong. & Ad. News, supra at 2018. The same report further provides:

> The Committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The Committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relatives, if able, for medical care. (Emphasis supplied)

Id. See Manfredi v. Maher, supra; Burns v. Vowell, 424 F. Supp. 1135, 1140-41 (S.D. Tex. 1976).

This Court joins other courts in holding that state procedures which "deem" a computed portion of a spouse's income to be available for an institutionalized spouse's expenses by the application of an arbitrary formula is contrary to 42 U.S.C. § 1396a(a)(17) as shown by its language and the expressed Congressional intent. Manfredi v. Maher, supra; Burns v. Vowell, supra; and Franssen v. Juras, supra.

This does not mean that the state may not seek some contribution from the non-institutionalized spouse. Congress has recognized that such spouse should be responsible for that portion

of an institutionalized spouse's expenses that he or she in fact is able to bear.

In Franssen v. Juras, supra, 406 F. Supp. at 1378 the Court said:

> Congressional purpose to calculate need with real rather than presumed dollars is evident from the report of the House Ways and Means Committee that accompanied the Medicaid bill.
> [quoting]
>
> Nonetheless, this prohibition against assuming sources of income is not intended to permit one spouse to spurn a normal obligation to support and assist the other merely by refusing to make contributions.

The Court took a similar position in Burns v. Vowell, 424 F. Supp. at 1141:

> Thus, while the income of a non-institutionalized spouse can be considered, it must be done through the application of reasonable standards and not on the basis of an irrebutable presumption that the money is available for the care and support of the institutionalized spouse. Deeming as employed by the Texas regulation is not consistent with the federal statutes and reguations, and cannot be employed to impute income. Thus where nursing home care is made available to eligible recipients, their spouses cannot 'be held accountable beyond their means'.

Although the operation of the State's formula as finally computed appears to make a reasonable allocation of income in the situation before the Court, it would seem to be merely coincidental. There has been no factual determination that this particular amount is reasonably available for the institutionalized spouse. In the Court's opinion, the state procedure must provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse. Otherwise the procedures will be in conflict with 42 U.S.C. § 1396a(a)(17). Such determination must give due consideration to the individual obligations and the particular needs of each spouse and family.

The Court concludes that the Iowa Department of Social Services Manual Letter No. XII-1-28 pt 2 dated June 3, 1977 is invalid.

REGULATIONS

Section 248.3(b), Code of Federal Regulations, effective January 13, 1977, provides in part:

> (b) with respect to both the categorically needy and if they are included in the plan, the medically needy, a State plan must:
>
> (a) (ii) Where only one spouse applies as aged, blind or disabled or is SSI eligible, and they cease to live together in a common household, only actually contributed income and resources

> may be considered available in determining the eligibility or amount of assistance of the applicant or recipient after the month during which they cease to live together. (Emphasis supplied)

Griswold v. Page, TCA 77-712 (N.D. Fla. filed May 20, 1977) states:

> All parties to this action concede that these regulations proscribe the deeming procedures outlined above.
> 14. HRS has revised its field manual to reflect and comply with the changes in the federal regulations. Effective for the period beginning May 1, 1977, the income of a non-institutionalized spouse will no longer be imputed to be available to defray the expenses of the institutionalized spouse once a thirty-day period has elapsed from the initial date of institutionalization.

As the Court has already held that the state procedures are contrary to the statute, it must and does hold that the procedures are also contrary to regulations which arbitrarily refuse to impute the income of a non-institutionalized spouse to defray expenses of an institutionalized spouse.

As the arbitrary denial of any right for the states to make a factual determination of a reasonable amount of a non-institutionalized spouse's income which may be imputed to the institutionalized spouse appears to be contrary to statements in this opinion and the cited cases, the Court feels compelled to make it clear that this decision should not be

interpreted as approving the amended regulations. Mr. Califano and HEW are not represented in this action and it is therefore not appropriate to make a finding on the validity of that section. However, it seems to the Court that "deeming" is contrary to congressional intent whether income of the non-institutionalized spouse is deemed available or unavailable.

A state should be allowed under the statute to require proof of actual expenses, deducting those amounts from gross income to determine the amount, if any, that might reasonably be required as a contribution to the support of the institutionalized spouse. This approach would appear decidedly more flexible and equitable in its overall operation and furtherance of congressional intent.

The Court does not consider it necessary or proper to consider the plaintiffs claims relative to the unconstitutionality of the state's deeming procedures. However, one issue does remain, that of plaintiffs' class action request. Since defendants have stipulated to this action being proper for class action procedures, the Court accepts plaintiffs' contention that the proper class pursuant to Fed. R. Civ. P. 23(a) and (b)(2) consists of all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under current state procedures, being deemed available to the institutionalized spouse. If the parties are unable to agree upon the proper notice and notice

procedures to be utilized, the Court will consider that issue at a later date.

IT IS THEREFORE ORDERED that plaintiffs' request for class action certification shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that the plaintiffs' request for final determination, which the Court elects to treat as a motion for summary judgment shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that plaintiffs' request for a permanent injunction against state "deeming" procedures shall be, and the same is hereby granted.

IT IS FURTHER ORDERED that any other matters not disposed of in this opinion and Order will be considered upon application of a party or parties.

Plaintiffs shall prepare a Judgment Entry in accordance herewith, obtain defendants approval as to form and submit it to this Court for signature.

Costs of this action are assessed against the defendants.

Signed this 19 day of January, 1978.

s/_____
W. C. Stuart, Chief Judge
Southern District of Iowa

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

FILED
JUL 10 1978

Clerk, U. S. District Court
Southern District of Iowa

ELVINA M. HERWEG, et al.,	)	
	)	CIVIL NO.
Plaintiffs,	)	77-222-1
vs.	)	
	)	RULING AND
ROBERT D. RAY, et al.,	)	ORDER
	)	
Defendants.	)	

On January 19, 1978 this Court entered a Memorandum Opinion and Order which granted plaintiffs' request for class certification, their motion for summary judgment and their request for a permanent injunction against state "deeming" procedures. Herweg v. Ray, 443 F. Supp. 1313 (S.D. Iowa 1978). On March 17, 1978 plaintiffs filed a request with this Court seeking an Order which would set forth specifically the contours of relief to which plaintiffs were entitled. Defendants joined in this motion on March 22, 1978 and at the same time filed a brief which argued against retroactive application of the Court's affirmative relief set forth in the January 19, 1978 Order. Plaintiffs responded on March 31, 1978 and the

matter came on for hearing on April 27, 1978. Appearing for plaintiffs were Gill Deford and Robert Bray. Appearing for defendant was Stephen Robinson. Supplemental briefs were filed May 10 and June 27 by plaintiffs and defendants respectively. The Court now considers the matter fully submitted.

Three primary issues remain to be resolved: (1) the contents of the class notice; (2) the question of retroactive application of the Court's original ruling; and (3) the sufficiency of defendant's modified procedures pursuant to the statutes and this Court's Order. These issues will be discussed in inverse order.

Proposed revised procedures of the State Department of Social Services provide generally for disregarding of certain income and for the individualized determination of the amount of a non-institutionalized spouse's income which is in fact reasonably available for the support of the institutionalized spouse. Plaintiffs contend that adequate provision is not made for the disregarding of Social Security benefits, 42 U.S.C. § 407, Railroad Retirement Board annuities, 45 U.S.C. § 231m, and Civil Service Commission annuities, 5 U.S.C. § 8346(a). Plaintiffs also claim "the strong possibility remains, given the bland nature of these instructions, that workers will simply use the work sheet as their format and not bother to determine whether other expenses could be deducted".

The Court agrees that the three specific items noted above should be specifically mentioned in the revised State procedures. With this exception, the

procedures are satisfactory. The comment to section 4(e) provides "[t]he items listed are not intended to be all inclusive or in any way a limitation". The Department of Social Services employs trained individuals who, in cooperation with affected individuals, make independent determinations of income and expense items. The Court will not assume that certain items of income, properly exempt under various federal provisions, will be included as income or that proper expenses will not be allowed. Should either event occur proper procedures are certainly available within the administration of the Department of Social Services without detailed and continual federal court supervision.

Plaintiffs major dispute with the revised procedures concerns what is perceived by them to be continued "deeming" of income to be available from the non-institutionalized spouse for the institutionalized spouse's care. Plaintiffs take issue with revised procedures which, as an initial premise, combine incomes of the institutionalized and non-institutionalized spouse and, only after such combination has been made, make provision for the reasonable requirements of the non-institutionalized spouse. Plaintiff argues that any available income of the non-institutionalized spouse cannot automatically be "deemed" available unless it is actually contributed and that contribution can be compelled only through relative responsibility laws which would place the burden to pay on the non-institutionalized spouse without jeopardizing the qualification status of the institutionalized spouse.

The Court disagrees with the plaintiffs. Although such a procedure might be possible under the relevant statutes, the State has undertaken the responsibility of formulating a plan that also complies with the applicable statutes. The existence of alternative procedures is irrelevant. Title 42 U.S.C. § 1396a(a) provides:

> A State plan for medical assistance must--(17) include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and . . . (C) provide for reasonable evaluation of any such income or resources . . .

In the Court's opinion the proposed State plan involved herein adequately fulfills these objectives. In its original Order this Court recognized that, although a State may not "deem" income to be available by use of an arbitrary formula, this does not mean that the State may not seek some contribution from the non-institutionalized spouse. Further this Court recognized, although it could not specially find, that deeming is contrary to Congressional intent regardless of whether income is deemed to be available or not available. The proposed plan here is, in this Court's opinion, entirely consistent with the federal law. Plaintiffs' interpretation, while

perhaps consistent as well, is not mandatory and does not invalidate the State plan.

The Court is of the opinion that the January 19, 1978 Order is properly retroactive to the date of the filing of the original complaint, July 28, 1977.

The form of notice to be sent to the plaintiff class, attached hereto as Exhibit A, is consistent with that approved by the Seventh Circuit in Jordon v. Trainor, 563 F.2d 873 (7th Cir. 1977), cert. granted, sub nom. Quern v. Jordan, No. 77-841, 46 U.S.L.W. 3541 (February 28, 1978). As that Court said:

> No judgment for any award of damages against the state comes from the federal court. The members of the class will be given no more by the proposed modified notice that what they would have gathered by sitting in the courtroom or by reading and listening to news accounts had the case attracted attention. As for the state, our decision means only that if an appeal be filed in the future by a class member, the state may determine for itself by its own procedures whether any back payment may be due the applicant.

Jordan v. Trainer, supra at 878. The case is even more clear here where any retroactive recovery to any member of the plaintiff class would amount only to reimbursement of payments improperly demanded rather than payment of amounts improperly withheld or actual damages to be

recovered. The Court hereby specifically approves the class notice attached.

IT IS THEREFORE ORDERED that the proposed manual letter submitted by defendants at hearing shall be, and the same is hereby specifically approved, except that it must specifically point out that Social Security benefits, Railroad Retirement Board annuities and Civil Service Commission annuities are to be disregarded.

IT IS FURTHER ORDERED that the Order of this Court dated January 19, 1978 shall be, and the same is hereby declared to be retroactive to July 28, 1977.

IT IS FURTHER ORDERED that the parties shall have ten (10) days from the date of this Order to submit objections, if any, to the class notice attached hereto. If no objections are filed, this notice shall be sent to all members of the class as expeditiously as possible.

Signed this 10 day of July, 1978.

s/ _____
W. C. Stuart, Chief Judge
Southern District of Iowa.

CLASS NOTICE

To all married couples residing in Iowa of which: (1) one spouse is eligible for Medicaid and requires institutionalization; and (2) the other spouse is not institutionalized; and (3) the non-institutionalized spouse has income which is, under [previous] state procedures, being deemed available to the institutionalized spouse.

Notice of Possible Eligibility to Recover Amounts Previously Paid to the Iowa Department of Social Services.

On January 19, 1978 the federal district Court for the Southern District of Iowa declared that the Iowa Department of Social Services was in violation of federal law by its method of computing the amount of income which a non-institutionalized spouse was required to contribute towards the care of an institutionalized spouse under the Medicaid program. The Iowa Department of Social Services was directed to modify its computation procedures as follows: "The State procedure must provide for a factual determination in each instance of the amount of the spouse's income which is in fact reasonably available for the support of the institutionalized spouse." The Iowa Department of Social Services has not modified its procedure in compliance with the Court's Order.

According to our records, you are a member of the class in whose behalf this case was brought. In accordance with the Court's Order the Department is under an obligation to return to you any amounts over and above those which would have represented a reasonable contribution to your spouse's care and which you would have been able

to contribute at a given time in the past. The Department must now compute your reasonable past contribution, and once that figure is reached, it can be determined whether or not you will be eligible to have any amount returned to you. You should contact your local office of the Department of Social Services to arrange for a determination of the amount which would have represented an appropriate contribution to your spouse's care in the past. If the Department determines that you are not eligible to be reimbursed, or if you disagree with the amount which they reach, you will, of course, have the right to appeal that decision in the normal manner.

Although you are under no obligation to take any action in response to this letter, it is to your benefit to do so. In the event it is determined that the originally computed amount was less than that you could reasonably have been expected to pay under the modified method of computation, you will not be required to make up the difference. On the other hand, if the Department previously required you to pay an amount greater than that determined under the modified method of computation you will be refunded the difference. You should contact your local office of the Department of Social Services to arrange for a determination of the amount you could have been expected to contribute under the modified method of computation.

If you have any questions about this letter or the procedure it outlines, you should contact the Department of Social Services, your own attorney, or your nearest legal aid or legal assistance office.

Victor Preisser, Commissioner of
the Iowa Department of Social Services.

APPENDIX D

JUDGMENT ON DECISION BY THE COURT

UNITED STATES DISTRICT COURT
FOR THE
SOUTHERN DISTRICT OF IOWA--
CENTRAL DIVISION

Civil Action File No.

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg; and Darrell E. Herweg, and all others similarly situated	) FINAL) JUDGMENT
vs.	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, et al	

This action came on for xxxx(hearing) before the Court, Honorable W. C. Stuart, United States District Judge, presiding, and the issues having been duly (heard) and a decision having been duly rendered,

It is Ordered and Adjudged that plaintiffs' request for class action certification is granted;

It is Further Ordered and Adjudged that plaintiffs' request for final determination has been treated by the Court as a motion for Summary Judgment and same is granted;

It is Further Ordered and Adjuged that plaintiffs' request for a permanent injunction against state "deeming" procedures is granted;

It is Further Ordered and Adjudged that any other matters not disposed of in the Opinion and Order will be considered upon application of a party or parties:

It is Further Ordered and Adjudged that that the Class Notice attached as Exhibit "A" to the Ruling and Order of July 10, 1978, shall be sent to all members of the class as expeditiously as possible.

It is Further Ordered and Adjudged that costs of this action incurred since the Bill of Costs filed February 15, 1978, are assessed against defendants.

Dated at Des Moines, Iowa, this 4th of August, 1978.

FILED
AUG 4 1978

Clerk, U. S. District Court
Southern District of Iowa

s/_____
Clerk of Court

APPENDIX E

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 78-1664

Elvina M. Herweg, by her husband and next friend, Darrell E. Herweg, and Darrell E. Herweg, and all others similarly situated,	*
Appellants,	* Appeal from the United States District Court for the Southern District of Iowa.
v.	
Robert D. Ray, individually and in his capacity as Governor of the State of Iowa, and Kevin J. Burns, individually and in his capacity as Commissioner of the Iowa Department of Social Services,	*
Appellees.	*

Filed: April 22, 1980

Before LAY, Chief Judge, HEANEY, BRIGHT, ROSS, STEPHENSON, HENLEY, McMILLIAN, ARNOLD, Circuit Judges, and GIBSON,* Senior Circuit Judge.

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* The Honorable Floyd R. Gibson was Chief Judge of the Eighth Circuit at the time this case was submitted and took senior status on December 31, 1979.

ORDER ON PETITION FOR REHEARING

The petition for rehearing is denied.

A true copy.

ATTEST:

CLERK, U. S. COURT OF
APPEALS, EIGHTH CIRCUIT.

APPENDIX F

1) 42 U.S.C. § 1396a(a)(10):

"A State plan for medical assistance must--

...

(10) provide--

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in Clause A; and

(C) if medical assistance is included for any group of individuals who are not described in Clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income

program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary--

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of

premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);"

2) 42 U.S.C. § 1396a(a)(17):

"A State plan for medical assistance must--

. . .

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in

the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State

program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;"

3) 42 U.S.C. § 1396a(f):

"(f) Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled invididual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such

individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from

income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection."

4) 42 C.F.R. § 435.723:

"Financial responsibility of spouses.

(a) If the agency provides medicaid to SSI recipients, it must meet the requirements of this section in determiing eligibility of aged, blind, and disabled individuals under the optional coverage provisions of §§ 435.210, 435.211, and 435.231.

(b) The agency must consider income and resources of spouses living in the same household as available to each other, whether or not they are actually contributed.

(c) If both spouses apply or are eligible as aged, blind, or disabled and cease to live together, the agency must consider their income and resources as available to each other for the first 6 months after the month they cease to live together. After this 6-month period, the agency must consider only the income and resources that are actually contributed by one spouse to the other.

(d) If only one spouse in a couple applies or is eligible and they cease to live together, the agency must consider only the income and resources of the eligible spouse that are actually contributed to the eligible spouse after the month in which they cease to live together."